III. CLAIMS SAVINGS GENERATED BY REFORMS

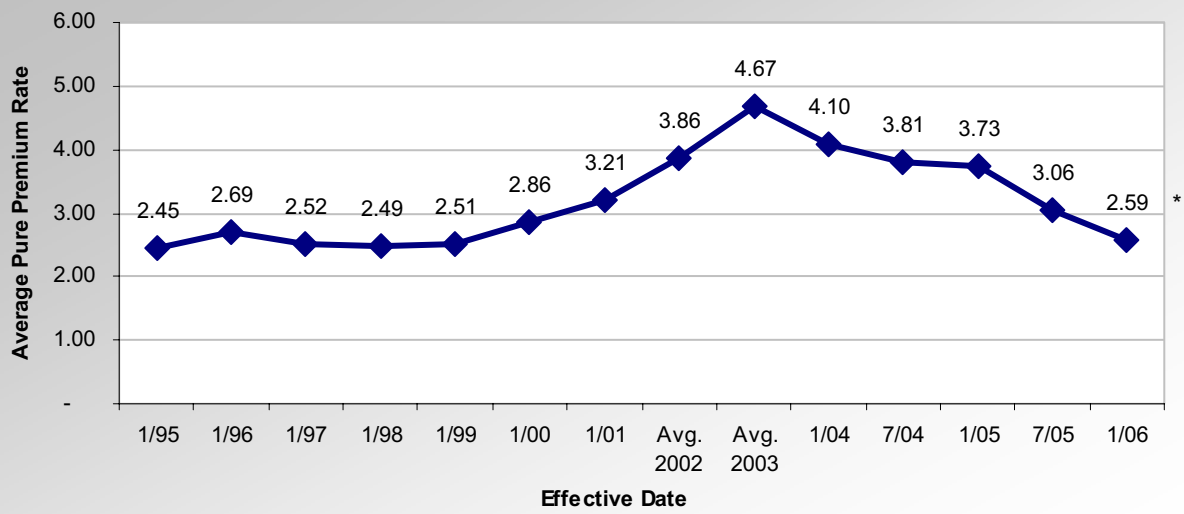
Actuarial Projected Savings

After reviewing recent industry loss experience and the many analyses which have been conducted to study the impact of the recent workers' compensation reforms, it is clear that in aggregate the reforms have had a substantial impact on reducing claims costs. This reduction in claims costs has been reflected in the pure premium rates adopted by the CDI since 2003.

Comparison to 2003 Pure Premium Rates: CDI

The reforms have clearly impacted the pure premium rates that were recommended by the WCIRB and also those that were approved by the CDI. The following exhibit shows the average CDI pure premium rates by policy period. These rates only reflect anticipated loss and loss adjustment expense. They do not include a charge for additional costs such as general overhead and agent/broker commissions.

Exhibit III.1. Average CDI Approved Pure Premium Rates



Source: WCIRB presentation at CDI public rate hearing, September 16, 2005. Data from WCRIB is adjusted to reflect CDI approved rate change.

The above exhibit shows that historical pure premiums at CDI approved rates can be broken into three time periods:

1995 – 1999: Rates are relatively stable

1999 – 2003: Rates increased by 86 percent (from 2.51 to 4.67)

2003 – 2006: Rates decreased by 45 percent (from 4.67 to 2.59)

One conclusion from the preceding exhibit is that the reforms have decreased costs by 45 percent. This is based on the fact that the pure premium rates decreased by 45 percent between 2003 and 2006. However, this interpretation makes the following four assumptions:

1. There has been no change in industry mix.
2. Absent reforms, claims costs would have remained level between 2003 and 2006.
3. 2003 rates were accurate.
4. 2006 rates are accurate

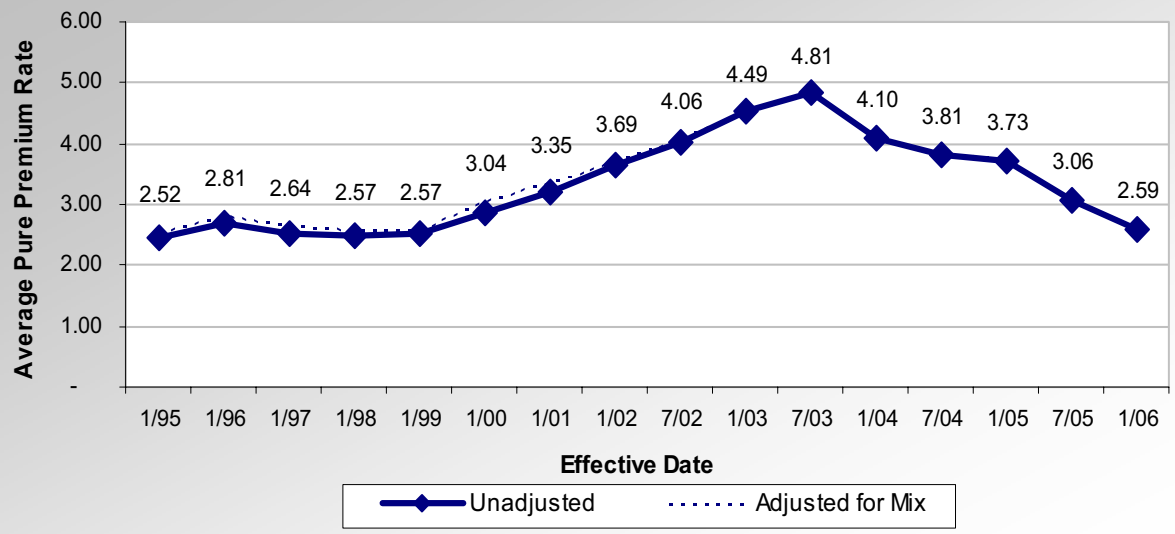
We will examine each of these assumptions in the following sections.

Change in Industry Mix

One of the difficulties with the preceding exhibit is that changes in average pure premium rates can be distorted by changes in the mix of payroll that is insured from one year to the next. For example, constructions policies tend to have a higher pure premium rate than a typical average policy in California. Therefore, if the California economy shifts towards a higher concentration of construction, then the average rate will increase. This rate increase would not be due to a change in the workers' compensation system, it would simply the result of the fact that different types of risks are insured from one year to the next.

The following exhibit shows the original pure premium rates as well the rates adjusted for changes in mix.

Exhibit III.2. Average CDI Pure Premium Adjusted for Mix



Note: 2002 and 2003 rates are interpolated based on annual averages

The previous exhibit shows that the adjustment for mix does not substantially alter the results. The mix-adjusted pure premium rates decreased by 46% (from $4.81 to $2.59) between July 2003 and January 2006.

In order to calculate the mix-adjusted rates, we initially started with the unadjusted January 2006 pure premium rates. Pure premium rates for earlier policy periods were calculated by dividing

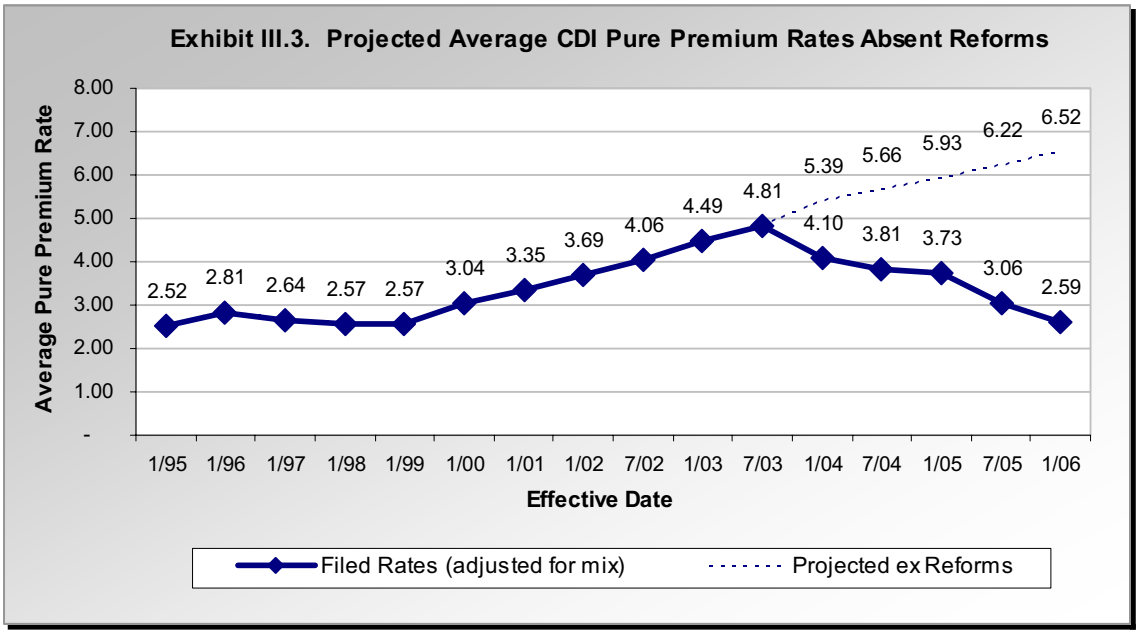
later rates by the CDI approved rate change. For example, the adjusted pure premium rate of $3.06 was calculated as follows:

$$\text{Pure Premium Rate June 2005} = \frac{\text{Pure Premium Rate January 2006}}{1 + \text{CDI approved January 2006 rate change}}$$

$3.06 = 2.59 / (1 – 0.153)$

Activity Between 2003 and 2006 Absent Reforms

A true measure of the impact of the reforms on 2006 rates should compare the actual 2006 rates versus what the 2006 rates would have been if there had not been reform. This comparison is very judgmental because we can only speculate as to what the 2006 rates would have been without reform. We do know, however, that prior to the reforms the average cost of indemnity claims was inflating at an average rate exceeding 10 percent per year, and the CDI approved rates increased at an annual rate exceeding 15 percent between 1999 and 2003. The following chart compares the mix-adjusted CDI pure premiums to those that might have occurred absent reform.



The dotted line in the previous exhibit shows the rates assuming the annual increase from July 2004 to 2006 would have slowed down to 10 percent. The January 2004 pure premium rate is based on the WCIRB pure premium rate change recommendation that was calculated prior to the enactment of AB 227 and SB 228.

Comparing the estimated 2006 rates without reform (dotted line) versus with reform (solid line) indicates that the reforms reduced rates by 60 percent (from $6.52 to $2.59). However, this result is speculative because it is impossible to know what the 2006 rates would have been without the reforms.

Accuracy of July 2003 Rates

The preceding projections in this section have assumed that the July 2003 rates approved by the CDI were accurate. For example, basing reform saving estimates on a comparison of the July 2003 and January 2006 rates assumes that the July 2003 rates are accurate. In addition, the projections of what the 2006 rates would have been without reforms start with the July 2003 rates as a base and then adjust for expected increases. So the comparison of 2006 rates with and without reforms also assumes that the July 2003 CDI approved rates were accurate.

Section VII of this report retrospectively tests the accuracy of WCIRB and CDI pure premium rates. Based on the results of that analysis, we have concluded that while the CDI approved a July 2003 rate increase of 7.2 percent, current estimates would have supported a rate reduction of 26 percent. A very important reason that the approved July 2003 CDI pure premium rates overestimated the projected losses is that the losses were impacted by future reforms (notably AB 227, SB 228 and SB 899) not anticipated in the July 2003 filing. In order to calculate the impact of the reforms, it is first necessary to project what the July 2003 rates should have been if there had been no reforms.

Adjustments for major reform provisions that impacted policies incepting between July 1, 2003, and December 31, 2003, are shown in Appendix B. The following exhibit displays our estimated adjustment for the adequacy of the July 1, 2003 rates.

Exhibit III.4. Adjustments for July 1, 2003 Rate Adequacy

	CDI	BRS Low	BRS Middle	BRS High
7/1/03 Average Pure Premium Rate	4.81			
Rate Adequacy Adjustment		25%	14%	2%
7/1/03 Adjusted Pure Premium Rate		3.84	4.23	4.70
1/1/06 Adjusted Pure Premium Rate (no reforms)		5.20	5.74	6.37
1/1/06 Approved Average Pure Rate	2.59			
Reduction in Rates				
vs. 7/1/03		33%	39%	45%
vs. 1/1/06 (as if there were no reforms)		50%	55%	59%

The above chart shows that the CDI approved January 1, 2006 rates are between 33 percent and 45 percent less than the July 1, 2003 rates after adjusting for rate adequacy. We also project that the approved January 1, 2006, rates are also roughly 50 percent to 60 percent less than they would have been without reforms.

Accuracy of January 2006 Rates: BRS Projections

The final adjustment necessary to quantify savings associated with the reforms relates to the adequacy of the January 1, 2006, rates recommended by the WCIRB and approved by the CDI. So far in this analysis we have calculated July 1, 2003, rates as if the reforms had not occurred and adjusted those rates for adequacy. We have also estimated January 1, 2006, rates as if the reforms had not occurred. The goal is to compare these rates to post-reform January 1, 2006, pure premium rates. The WCIRB has recommended - and the CDI has approved – rates for January 1, 2006. We have reviewed those rates and independently arrived at our own conclusion of the proper January 1, 2006, rates.

First, it is important to acknowledge that there is still significant uncertainty regarding the amount of claims cost savings that will result from the reforms. Part of the reason for this uncertainty is that workers' compensation costs have a long payout pattern. For example, the WCIRB estimates that less than 21 percent of the total medical and indemnity costs associated with injuries occurring in 2004 had been paid out June 30, 2005.[1] The 79 percent of costs which have not yet been paid are still estimates, and they are subject to changes in inflation, the use of loopholes in the reforms, unanticipated legal decisions, and future legislative/regulatory reform.

We have projected savings at low, middle, and high levels in order to reflect a reasonable range of the impact of the reforms. None of our assumptions reflect future legislative or regulatory changes. We are not able to predict these, even though they could potentially have a very significant impact on savings estimates from the reforms.

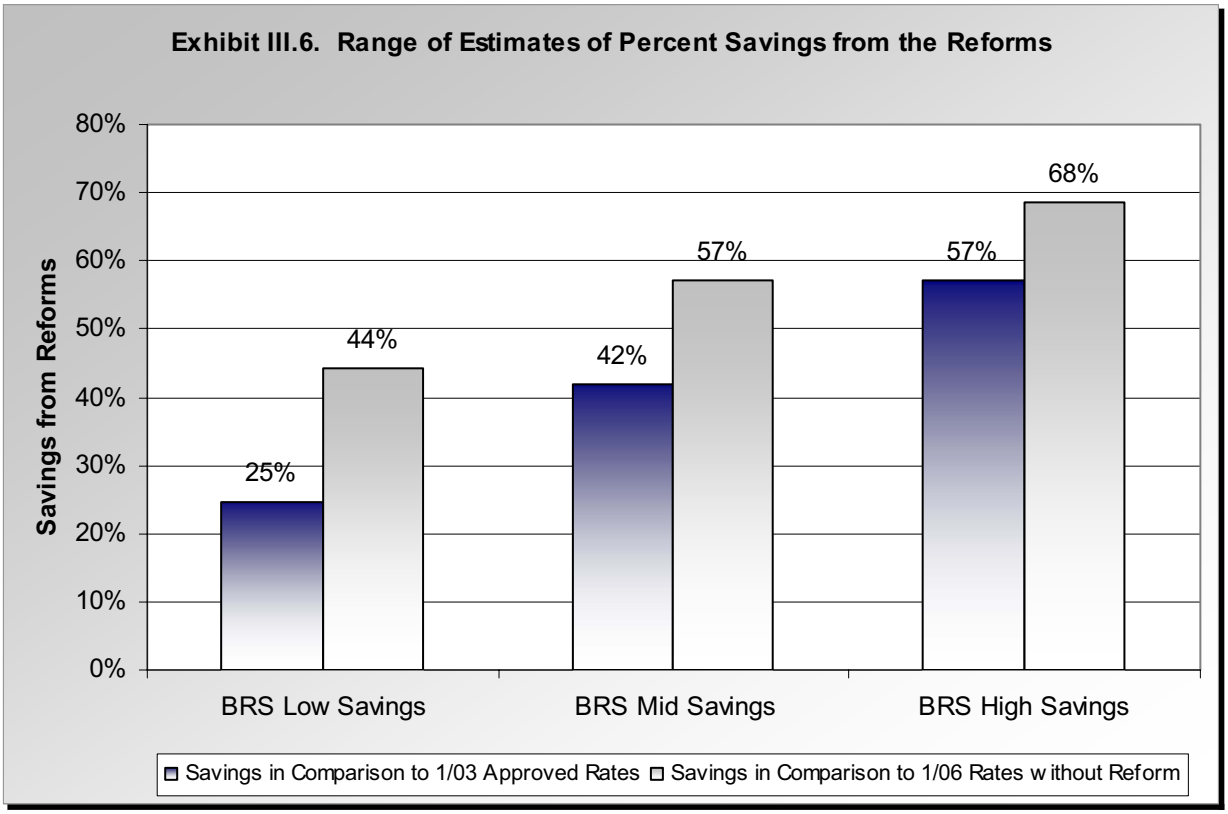
The following exhibit compares the WCIRB, CDI, and BRS estimated average pure premium for January 1, 2006, after reflecting the reforms.

Exhibit III.5. Estimated January 1, 2006, Pure Premium Rates (Post-reform)

	BRS	CDI	WCIRB
Low Savings	2.90		
Middle Savings	2.46	2.59	2.57
High Savings	2.01		

The above exhibit shows that the WCIRB and CDI projections are within the range of our Low, Middle, and High estimates.

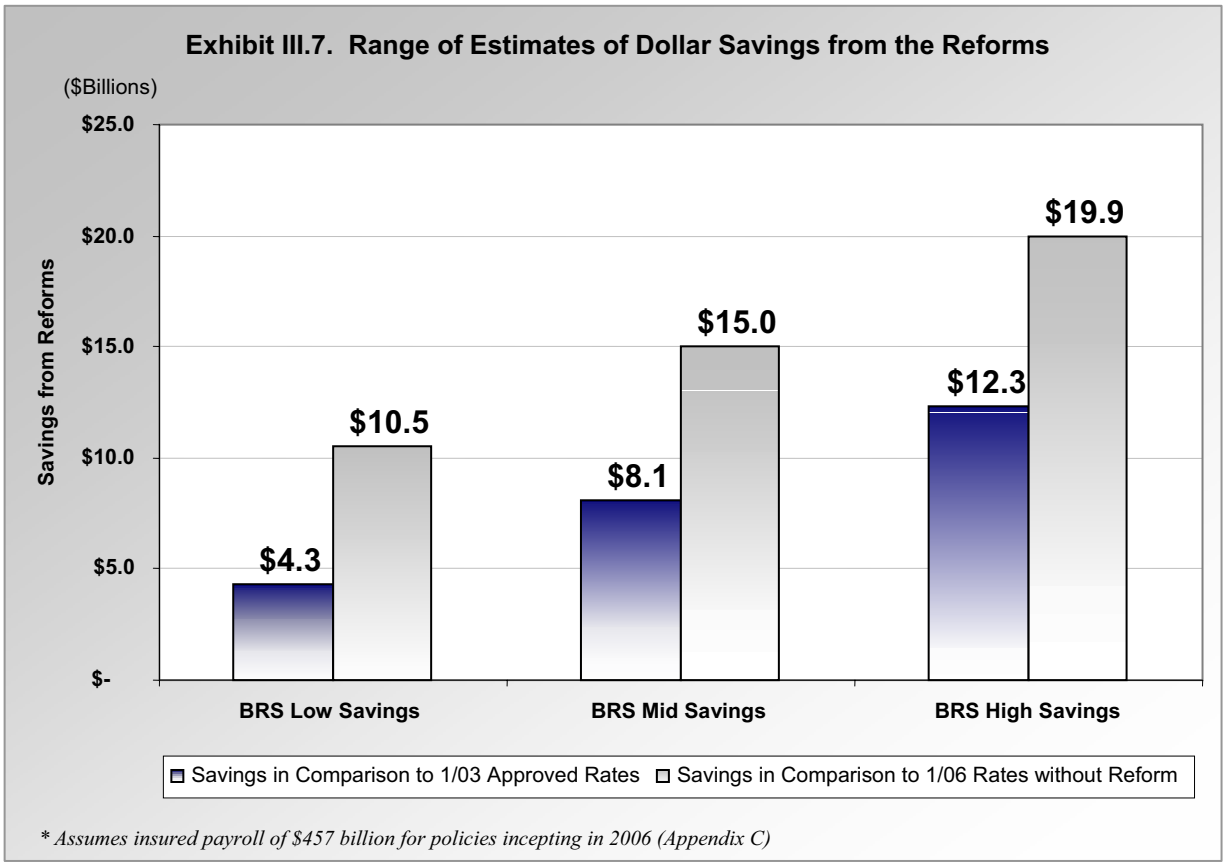
The following exhibit shows the BRS projected percentage savings from the reforms for policies incepting in 2006.



For each set of estimates, the left-hand column represents the savings in comparison to July 1, 2003 pure premium rates adjusted for changes in mix and rate adequacy. For example the BRS Low Savings projects that the pure premiums for policies incepting in 2006 should be 25 percent lower than comparable July 1, 2003 rates.

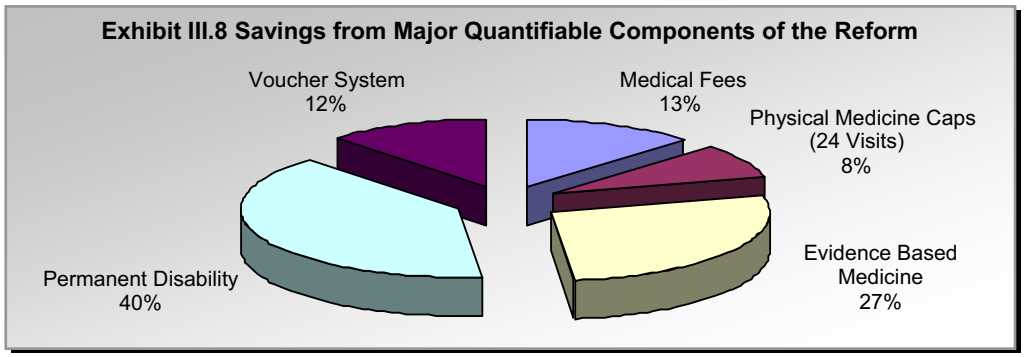
The right-hand columns represent percentage savings in comparison to what the 2006 rates might have been if there had been no reforms. This assumes that without the reforms, rates would have inflated at an annual rate of 10 percent between 2004 and 2006.

The following exhibits display the projected dollar savings resulting from the reforms. It is important to stress that there is still significant uncertainty pertaining to the percentage of loss reductions resulting from the reforms. Converting the percentage to dollars, as is done in the above exhibit, required additional assumptions regarding what ultimate cost would have been absent the reforms.



Major Components of the Reforms

It is very difficult to break down the savings associated with the reforms into individual pieces. This difficulty stems from the fact that the impacts of the different reforms overlap each other, and each reform contained many components affecting costs. There has been - and there continues to be – a great deal of analysis of the affects of individual components of the reforms. However, the aggregate impact of the reforms is already showing up in more recent loss data, and it is impossible to fully identify which reform provision lead to changes in the loss data. The following exhibit provides a breakout of those pieces which we feel can be reasonably quantified:



The following exhibit shows the BRS assumptions regarding the impacts of major pieces of the reforms on loss and loss expense.

Exhibit III.9. Projected Savings by Major Reform Component

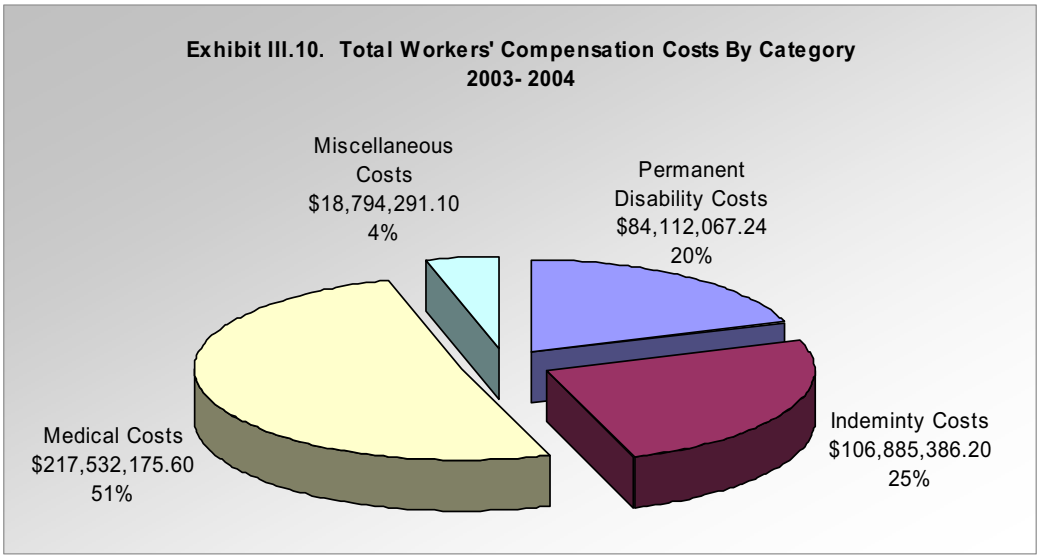
Component	Pre-dominant Reform	Inception	Retro-Active	As a % of Total Cost (pre-reform)	Savings (Percent of Total Cost)* Low	Middle	High
Medical Cost Components							
Medical Fee Schedule Changes							
Physician Fees	SB 228	1/1/2004	Yes	30%			
Inpatient Fees	SB 228	1/1/2004	Yes	7%			
Outpatient Facility Fees	SB 228	1/1/2004	Yes	10%			
Pharmaceutical Fees	SB 228	1/1/2004	Yes	4%			
Total				51%	(5.5%)	(5.5%)	(5.5%)
Medical Utilization Provisions							
Physical Medicine Limitations (24 visits)	SB 228	1/1/2004	No	9%	(3.5%)	(3.5%)	(3.5%)
Chiropractic	incl. above						
Physical Therapy	incl. above						
Occupational Therapy	SB 899	4/19/2004					
Other Utilization Provisions				55%	(5.9%)	(11.8%)	(17.7%)
ACOEM enacted 1.1.04[1]	SB 228	1/1/2004	Yes				
ACOEM strengthened by SB899	SB 899	4/19/2004	Yes				
Medical Provider Networks	SB 899	1/1/2005					
Immediate Medical Pay[2]	SB 899	4/19/2004	Yes	55%	0.4%	0.4%	0.4%
Medical Legal							
Partial repeal PTP presumption & Other[3]	AB 749	1/1/2003	Yes	2%	(0.2%)	(0.2%)	(0.2%)
Fully repealed PTP presumption & Other[4]	SB899	4/19/2004	Yes				
Indemnity Cost Components							
Temporary Disability Limitations (2-Yr. Max)	SB 899	4/19/2004	No	13%	(2.2%)	(2.2%)	(2.2%)
Vouchers replace Vocational Rehabilitation[5]	AB 227	1/1/2004	No	6%	(5.2%)	(5.2%)	(5.2%)
Permanent Disability Benefits				21%			
Apportionment	SB 899	4/19/2004	Yes		(1.3%)	(2.2%)	(3.2%)
Change in # of Weeks	SB 899	1/1/2005	No		(2.2%)	(2.2%)	(2.2%)
Return to Work Adjustments	SB 899	1/1/2005	No		(0.7%)	(0.7%)	(0.7%)
Permanent Disability Rating Schedule[6]	SB 899	1/1/2005	Yes				
No Longer Ratable	SB 899	4/19/2004	Yes				
Total ex Apportionment					(6.9%)	(11.9%)	(15.9%)
Total Savings of Individual Components					(29%)	(38%)	(45%)
Savings Already in Loss Experience or from Other Components					(8%)	(19%)	(33%)
Grand Total Savings**					(34%)	(49%)	(63%)

* Note: Savings ranging from low to high as projected by BRS.
** Note: Grand Total Savings based on average of comparison to adjusted 7/1/03 and 1/1/06 rates

The percentages of total costs are based on pre-reform distributions. These imply that total costs are distributed as follows:

Permanent Disability	21 percent
Other Indemnity	19 percent
Medical Subject to Utilization Changes	55 percent
Other	5 percent

This distribution is very similar to a recent survey by the California League of Cities, which assigned 2003-2004 workers' compensation losses as follows:



A detailed discussion of BRS assumptions related to claims savings from the reforms, as well as a comparison to WCIRB and CDI assumptions, is in Section VII of this report.

Claims Review by Major Reform Category

General Findings and Observations

While approximately nine major elements of reform were considered in the claim review process, the following key trends emerged:

- Utilization Review: The provision of utilization review services in conjunction with evidence based medicine guidelines, notably those of the American College of Occupational and Environmental Medicine (ACOEM), has helped the insurance community effectively manage the cost of medical treatment in a manner that is also generally responsive to the treatment needs of injured workers.
- AMA Guides: The right schedule (the old permanent disability schedule or the new schedule based on the AMA Guides, 5th Edition) is generally being applied when carriers are assessing permanent disability obligations. Further, apportionment is generally being pursued when the opportunity to do so presents itself.

- Vouchers: Injured workers who may qualify for vouchers as a result of their permanent inability to return to their former employment following their industrial accidents may find that carriers either elect to settle the obligation or pay for schooling. In either case, the decline in vocational costs is dramatic.
- Medical Benefit Cap: The $10K medical benefit cap on delayed claims appears to have marginal to no significance on costs. Carriers are generally pursuing resolution of delayed claims without using the panel QME process.
- MPNs: While difficult to track because of a general lack of documentation, MPN claims do exist. Where we found MPN documentation occurring was either at the front end of a claim because the adjuster noted this or when an injured worker sought to change physicians and wanted to use a physician outside the network. In those cases, most of which occurred when the workers were represented, carriers typically afforded a panel of providers within the MPN for the worker to make a selection. Typically, this process was not challenged by counsel. We noted fewer instances where carriers who could exercise control through the MPN missed the opportunity to do so. We were unable to find a pattern of migrating existing claims (transfer of care) into the MPN. Carriers see this as an area rife with litigation potential. We tended to see it as a missed opportunity. That is, if you send out a transfer of care letter and the injured worker or his/her provider does not object then the transfer takes place. If there is an objection, then the carrier can choose to abide by the objection without litigating the matter.

Approach to Analysis

One component of the study team's activities consisted of a review of workers' compensation claims to evaluate the extent to which certain elements of reform have been implemented and the general impact of the changes brought about through reform.

The study team selected specific elements of reform that would permit analysis following these claim reviews. For instance, utilization review practices and the management of permanent disability could be observed in claim reviews. By contrast, a claim review focusing on such reform areas as temporary disability rates or fee schedule changes would not add value to the analyses that could already be accomplished through statistical measures.

All claim reviews were conducted in confidence. By agreement, the names of the carriers and the identities of the more than 400 individual injured workers whose claims were reviewed are not being divulged in this report. Further, our findings are aggregated for all carriers, and any conclusions we draw about industry performance are not specifically related to the practices of any one carrier.

A total of 404 claims were reviewed. Aggregate paid and incurred financial information is provided in the two exhibits that follow. Of the claims reviewed, the average paid amounted to $39,489. The average incurred amounted to $69,566.

Exhibit III.11. Paid Loss Summary Table				
Date Range	**Medical Paid**	**Indemnity Paid**	**Expense Paid**	**Total Paid**
Prior to 4/19/04	$5,834,332	$5,112,106	$858,454	$11,804,892
4/19/04 – 12/31/04	$1,183,115	$1,479,377	$243,118	$2,905,610
1/1/05 – Present	$782,133	$424,562	$36,392	$1,243,087
Financial Totals	**$7,799,580**	**$7,016,045**	**$1,137,964**	**$15,953,589**

Exhibit III.12. Incurred (Inc) Loss Summary Table				
Date Range	**Medical Inc**	**Indemnity Inc**	**Expense Inc**	**Total Inc**
Prior to 4/19/04	$10,551,948	$7,751,576	$1,182,293	$19,485,817
4/19/04 – 12/31/04	$2,278,436	$2,468,157	$440,758	$5,187,351
1/1/05 – Present	$1,881,772	$1,318,587	$231,307	$3,431,666
Financial Totals	**$14,712,156**	**$11,538,320**	**$1,854,358**	**$28,104,834**

Cases were of varying severities, from all parts of the state, and included a reasonable percentage of claims with injury dates predating reform. While our claim review teams conducted their review from one office for each of the selected carriers, claims were included in the sample from offices around the state. For instance, a carrier might services claims from three locations in California. In that case, claims were selected from each of those offices.

Prior to reviewing claims, a review template was developed (refer to Appendix D). The template was drafted and reviewed by claims, actuarial and legal study participants and also reviewed with DWC Audit Unit staff. The template was deliberately limited to those areas of reform which we felt could be analyzed through a claim review process. For instance, utilization review was part of the claim review template whereas changes to the fee schedule or benefit rates were not.

The claim samples for each carrier relied on the same selection criteria. Those selection criteria included:

- 50 claims on which UR services were provided with 30 percent to 50 percent of those cases including claims with dates of injury prior to January 1, 2004
- 10 denied claims (five with dates of injury prior to 4/19/04 and five with dates of injury after April 19, 2004)
- 25 PD claims where the requested mix was five claims with dates of injury prior to April 19, 2004, 15 with dates of injury between April 19, 2004 and five with dates of injury in 2005
- 5 Voucher claims
- 10 MPN claims

As there were overlaps in the types of services and benefits provided on these claims, we were able to see a broader sample of cases in each selected area than might be expected on first review of the selection. For instance, while our overall expectation was to see a minimum of 100 permanent disability claims, we actually reviewed 224 such claims. Over 300 claims contained utilization review services although only 200 were selected in the sampling process.

Some of the claim selections were made at random while the carriers selected other claims. The carriers had to be involved in the claim selection to some extent. The participation of carriers in

the claim selection process was required as some claims, in which the study team had interest, could only be pulled by canvassing insurance carrier claim staffs. Claim review results did not appear to be influenced by the extent to which a carrier participated in the direct selection of claims to be reviewed.

The sample was structured to assess nine topics broadly. These included:

1. Utilization Review
2. Repeal of the Presumption of Correctness for the Primary Treating Physician
3. Medical Provider Networks
4. AMA Guides
5. Apportionment
6. Two-tiered Permanent Disability
7. Vouchers
8. Delay Claim $10K Cap
9. Medical Legal Process

- In analyzing certain aspects of reform, we sorted claims in three distinct groups. The first group consisted of claims with dates of injury on or before April 18, 2004. The second group was limited to claims with dates of injury between April 19, 2004 and December 31, 2004, coinciding with the adoption of SB899 and preceding the implementation of such reform features as MPNs and the use of AMA Guides. The third injury grouping contained claims with dates of injury on or after 1/1/05.
- In general, the panel QME process is circumvented whether injured workers are represented or not.
- In general, reserving practices do not seem to have been influenced much by changes in the statute. One exception, somewhat difficult to track, is in the area of physical medicine services where adjusters know that they need not reserve for more than the value of 24 visits.

Overview: Utilization Review

Effective January 1, 2004, Utilization Review (UR) became mandatory for all injuries per Labor Code Section 4610. It requires every employer, directly or indirectly through an entity contracted for such services, to establish written UR policies and procedures that "prospectively, retrospectively, or concurrently review and approve, modify, delay or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600." This new stricter authorization guideline required a determination whether the proposed treatment is medically necessary to cure and relieve the effects of the industrial injury. The objective was to preclude medical care that is unreasonable, unnecessary, or deleterious. In complying with this Section, employers must file UR plans with the Administrative Director (AD), and these plans must be made available to employees, physicians and the public upon request.

The Administrative Director (AD) in consultation with the Commission on Health and Safety and Workers' Compensation (CHSWC) was required on or before December 1, 2004 to adopt a medical treatment utilization schedule that incorporated evidence based, peer reviewed, nationally recognized standards of care recommended by the Commission. The schedule was to address the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. The schedule would be presumptively correct.

The schedule in effect as of January 1, 2004, was the American College of Occupational and Environmental Medicine (ACOEM) practice guidelines. The purpose of the ACOEM guidelines is to improve the quality of treatment for injuries that are potentially work related and reduce variation in the quality of care. They address treatment for musculoskeletal, stress and eye conditions and include recommendations concerning surgery. They do not supersede the physical medicine caps in place under LC4064.5(d) for chiropractic/physical therapy/occupational therapy.

Other utilization guidelines, when used, must be consistent with the AD's treatment utilization schedule or the ACOEM Guidelines, but will not be considered presumptively correct. As of this writing, ACOEM guidelines are still presumptively correct. To overcome the presumption, the provider must cite specific factors, not simply an opinion, to show why the guidelines may not apply.

In practice, claims administrators are limited to full authorization of treatment only. Any delay, denial, or modification of medical treatment requires a medical opinion to support the action. One exception to this practice is if the treating medical provider, in consultation with nurse case managers or claims personnel, agrees to modify recommended treatment. Otherwise, UR physicians must provide treatment modifications. These physicians must also be available by telephone to discuss authorizations with those providers whose treatment requests have been modified.

Prospective or concurrent decisions must be made within five (5) working days from the receipt of the information reasonably necessary to make the determination, but no more than fourteen (14) days from the date of treating provider's request. Retrospective reviews must be completed within thirty (30) days from receipt of information reasonably necessary to make the determination. If the employee faces serious or imminent threat to his/her health that would constitute potential loss of life, limb or other major bodily function, or where delay would be detrimental to life or health, or could jeopardize the employee's ability to regain maximum function, the timeframes for medical review are shortened to no more than 72 hours from receipt of information reasonably necessary to make the determination.

Communication to the treating physician regarding decisions relating to medical treatment requests is also under a strict timeframe. Further, where medical information reasonably necessary to make the UR determination has not been provided, additional diagnostic work up is necessary or a medical expert is being consulted, the medical provider must immediately be notified that a decision cannot be made within the required timeframes, what additional information is required the make the decision, and the anticipated date that the decision will be

made. Those decisions resulting in modification, delay, or denial of all or part of the requested services must be communicated to the treating physician by telephone or facsimile initially, with written follow up within 24 hours for concurrent review or two (2) business days for prospective review.

Disputes in the UR process are resolved in accordance with Labor Code Section 4062, with the exception of a dispute for spinal surgery. Where a request to perform spinal surgery is disputed, Labor Code Section 4062(b) applies.

Labor Code Section 5814 administrative penalties can be pursued and awarded any time there is an unreasonable delay in the completion of the utilization guidelines, or if the review time, itself, is found to be unreasonable.

Findings: Utilization Review

In our analysis of utilization review (UR) services, we observed that carriers used UR services prior to 2004. However, the frequency with which UR services were utilized dramatically increased in 2004 following the enactment of legislation where the presumptive correctness of ACOEM replaced that previously associated with the primary treating physician. To accommodate the demand for more services, carriers retained additional staff and/or outsourced these services.

Of the claims reviewed, more than 75 percent had at least one utilization review intervention. A total of 1,029 UR interventions occurred in the claims sampled. Of that number, 736 were certified, a rate of slightly more than 71 percent. Physical therapy and chiropractic services tended to be the most frequent of the decertified services. In some of these cases, alternative modalities, such as home exercise programs, were recommended.

Prior to January 1, 2004, carriers used some form of cost containment or utilization review on their claims, but its impact was marginalized by the presumption of correctness afforded to the primary treating physician. Carrier cost containment efforts could include medical case management services or defense medical legal evaluations to evaluate treatment necessity and/or relatedness. However, by early 2004, carriers that participated in the claim review process had devised and documented their own UR plans and filed them with the Administrative Director.

In implementing UR plans, carriers relied upon various approaches. For instance, some carriers added nursing staff while others outsourced a much greater volume of medical management business. Considerable staff training was required to implement the process. Companies retained either directly or by independent arrangement medical directors to oversee claims on which medical treatment is delayed, modified, or non-certified.

To one degree or another, carriers also developed links between UR and their bill review process to ensure that medical reimbursements made by the bill review staff were consistent with authorized services. Typically, claim departments have the authority to certify treatment that may have been modified or decertified in the UR process. We observed that this discretion was infrequently applied, particularly as UR service plans matured.

Of the claims reviewed, UR interventions occurred on 77 percent of them (312 of 404). Within the sample, it appeared that UR services may have been warranted on a total of 349 claims, suggesting that UR services occurred on 89 percent of the applicable claims (312 of 349). We found that UR was just as likely to be used on older cases as on claims with more recent dates of injury, but that the frequency of intervention increased significantly in the middle of 2004.

Where treatment was referred to UR, most UR reviews appeared to be timely and effective in the concurrent and prospective review process. Very little retrospective review was in evidence. One carrier's program did provide retrospective reviews of emergency room treatment, as well as private physician care provided prior to direction into the MPN.

Within the population of claims on which UR services were provided, there were 1,036 interventions. Of that number, 296 were decertified meaning that in 71 percent (740 of 1,036) of the interventions medical treatment requests were approved. Statistics are provided in the following exhibit showing UR results sorted by injury grouping.

Exhibit III.13. Utilization Review Results by Injury Group

	UR apply	UR/Attempt to control	No. of Interventions	Average No. Interventions/Claim	No. of Decerts	Percent of Decerts
Pre-4/19/04	126	118	464	3.93	129	28%
4/19/04-12/31/04	106	88	294	3.34	100	34%
Post-1/1/05	117	106	278	2.62	67	24%
Grand Total	**349**	**312**	**1,036**	**3.32**	**296**	**29%**

Generally, decisions to decertify medical treatment were not challenged by medical providers. Some decisions to decertify occurred because providers may have submitted inadequate information to support requests for treatment, but most decisions to decertify occurred as a result of these requests being outside ACOEM guidelines. Except in those cases where additional medical information was needed, nearly all decisions to decertify were not appealed. As a result, medical costs are being reduced by UR intervention, and there are proportionately few cases that are appealed.

The most frequent interventions were in the physical medicine and diagnostics areas. As may be expected, most requests for services were approved. This is an indication that a significant percentage of treatment requests comply with ACOEM guidelines.

In an effort to analyze UR services, we assigned a subjective value to each intervention. The subjective values were unfavorable, neutral, and favorable. Unfavorable interventions were those where either the decisions either unreasonably delayed needed medical treatment, or decertified diagnostic studies that were needed by providers for bona fide treatment decisions. Favorable interventions were those where some cost control measures were reasonably exercised and in keeping with treatment guidelines. Favorable interventions could include situations where compensability issues were being addressed as well as those where services were modified, limited, or decertified. A modified service could be one where diagnostic studies were appropriately authorized as an alternative or precursor to a surgical intervention. Neutral interventions generally tended to be those where the treatment requests seemed to be routine and

they were authorized. The following exhibit divides the interventions according to our subjective values.

Exhibit III.14. Subjective Assessment of UR Interventions

UR Effectiveness Category Level	UR/Attempt to control costs	Number of Interventions	Number of Decerts	% of Decerts to Interventions
	13	53	17	32%
	220	585	102	17%
Favorable	79	398	177	44%
Totals	**312**	**1,036**	**296**	**29%**

While these assessments were subjective, it is worth noting that in only about 5% of the interventions (53 of 1,036) were the results unfavorable. Given the relative youth of these UR programs, this result suggests that carriers are generally not abusing their entitlement to rely upon ACOEM or other evidence based medicine guidelines to assess treatment needs. Further, in only about 6 percent (17 of 296) of the cases were decisions to decertify unfavorable.

One area of claims management where UR services can be used more is on those cases that are on delay. While carriers may be obligated to pay up to $10,000 for medical services on delayed claims, the care should be limited to what is believed to be within treatment guidelines. Within the claim review sample, there were 17 delayed cases with dates of injury on or after 1/1/05. UR services were observed on only three of these claims.

The issue of medical treatment in cases where nature and extent of injury is in dispute is still chiefly managed through the medical legal process. Where the medical legal process is managed timely and UR keeps step with claim strategies, the combination of UR and use of the medical legal process is very effective at controlling overall costs associated with these issues.

One favorable offshoot of effective UR services is that claims can move through the system quicker. For instance, several surgical claims in the sample with dates of injury in 2004 had been settled. In those cases, medical treatment and temporary disability were appropriately managed through the UR process, permanent disability benefits were assessed according to the appropriate schedule, and voucher benefits were considered and appropriately tied to the permanent disability rating on cases where injured workers could not return to work with their pre-injury employers.

In theory, ACOEM guidelines have a rebuttable presumption of correctness on the issue of treatment medically necessary to cure and relieve the effects of the industrial injury. All carriers commented on the difficulty they are currently experiencing with adverse WCAB decisions regarding the presumptive nature of ACOEM guidelines in chronic cases (*Hamilton v. SCIF* and *Casillas v. San Luis Obispo County*). This is creating an atmosphere of unwillingness to rely upon UR decertification in litigated claims.

In summary, the value of UR would seem second only to fee schedule changes in helping to manage medical costs in the post-reform era. Utilization Review has generally proven an effective deterrent to unnecessary medical treatment. However, there remains uncertainty within the workers' compensation community as to the relative merits of UR positions when UR

decisions are to be litigated. As the statutes governing medical treatment are relatively new, case law is still developing in the utilization review arena. As legal ambiguities are resolved, less litigation is likely.

Overview: Repeal of the Presumption of Correctness for the Primary Treating Physician

The California legislature passed AB110 in 1993 with the intent of reducing litigation by giving the primary treating physician the presumption of correctness in legal proceedings regarding the issue of permanent disability. The PTP presumption applied to all dates of injury 1/1/94 and after. The 1996 *Minniear* decision further changed the landscape by giving a legal presumption of correctness to the opinion of the Primary Treating Physician (PTP) against all other opinions when the issue was medical treatment and, in addition, defined a higher standard of what was required to rebut the PTP's opinion. This presumption applied to all compensability issues, was rebuttable by a preponderance of the medical evidence, and did not apply where both parties selected Qualified Medical Evaluators to resolve the dispute. In that set of circumstances, employers had difficulty introducing evidence to overcome both the physician's testimony via reports and the presumption of correctness concerning extent and scope of care.

The application of the *Minniear* decision coincided with a rapid increase in medical and indemnity costs, suggesting a link between PTP presumption and higher medical treatment and disability costs.[2] In general, the impact of the application of the presumption to medical treatment had been to increase both the frequency and intensity of moderately priced treatments. For example, workers selecting their own doctor might have more physical therapy visits and receive more specific therapies with each visit.[3]

Effective 1/1/04, SB 228 modified the PTP presumption to include all dates of injury, including those prior to 1/1/94. For dates of injury prior to 2003, PTPs had the presumption except for extent and scope of medical treatment. For dates of injury on or after 1/1/03, properly pre-designated PTP physicians and chiropractors had the PTP presumption except for extent and scope of medical treatment. ACOEM guidelines were presumed correct for extent and scope of care. The PTP presumption did not apply when there was a dispute and both parties selected Qualified Medical Evaluators. Where the PTP presumption was still in play, it was rebuttable by a preponderance of the medical evidence. Using the standards set forth in *Minniear*; the applicant's testimony will not rebut the presumption, the sequence of evaluations is irrelevant, and specific factors must be referenced in the medical legal report. Substantive medical legal reports in accordance with CCR10606 were more likely to be found to have more weight. The repeal of the PTP presumption for extent and scope of medical treatment could not be used to support a claim to rescind, alter, or amend any order, decision, or award of the Workers' Compensation Appeals Board.

Effective 4/19/04, SB 899 completely repealed the PTP presumption <u>for all issues</u> and all dates of injury. The effect of this piece of legislation is that any admissible medical report is equal before the law, and it applies to every case where the Workers' Compensation Appeals Board (WCAB) has not issued an award as of 4/19/04.

Findings: Repeal of the Presumption of Correctness for the Primary Treating Physician

As the presumption of correctness for the PTP has been repealed, there are no specific findings to make. In place of this presumption, we now find the Utilization Review (UR) guidelines, the medical treatment utilization schedule (currently ACOEM), the formulation of Medical Provider Networks (MPN) and a revised medical legal dispute resolution process.

One observation we can make is this: With medical treatment being managed through the UR process, carriers are tending to rely upon the opinions of PTPs when evaluating permanent partial disability. This approach tends to minimize disputes and speed up claim resolutions.

Overview: Medical Provider Networks

Effective 1/1/05, employers and insurers are eligible to establish medical provider networks (MPNs) to provide medical treatment for employees injured at work. Those with existing medical networks, i.e. previously certified health care organizations, health care service plans, group disability insurance policies or Taft-Hartley health and welfare funds, have the ability to modify their existing networks to meet MPN requirements.

There is a goal that at least 25 percent of the physicians in the network be primarily engaged in the treatment of non-occupational injuries with the balance of physicians primarily engaged in the treatment of occupational injuries. The network is required to have a sufficient number of physicians to provide treatment in a timely manner. It will include an adequate number and type of physicians (California licensed physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners pursuant to Labor Code Sections 3209.3 and 3209.5) to be able to be readily available at all times to treat the most common injuries employees experience, based upon the employer's type of occupation or industry, and the geographic area where the employee is employed.

The employer or insurer has the exclusive right to determine the selection of providers in the network. Physician compensation may not be structured in any way to achieve the goal of reducing, delaying, or denying medical treatment, or restricting access to medical treatment. All treatment must be provided according to utilization guidelines in effect, currently ACOEM.

In situations where employees are receiving treatment prior to the MPN implementation, and the employee's treating physician is a provider within the MPN, the employee and provider will be notified that treatment is being provided by his/her provider under the new MPN provisions.

Where employees being treated outside the MPN for an occupational injury or illness that occurred prior to the coverage of MPN, and whose treating physician is not a provider within the MPN, including employees that pre-designated a physician and do not fall into Labor Code Section 4600(d), consideration for transfer of care into the MPN will be made on a case-by-case basis according to the following conditions[4]:

Exhibit III.15. Transfer of Care Exceptions		
Type of Condition	**Definition of Condition**	**Length of care provision**
Acute	Sudden onset of symptoms, requires prompt attention, limited duration	Duration of the acute condition
Serious chronic	Illness, disease, medical disorder/problem that persists without full cure or worsens over an extended time, or requires ongoing treatment to maintain remission or prevent deterioration	Period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider approved by the employer, not to exceed 12 months from the physician's contract termination date
Terminal illness	Incurable or irreversible condition with a high probability of death within one year or less	Duration of the terminal illness
Surgery, other procedure	Procedure previously authorized as part of the documented treatment, and is scheduled to occur within 180 days of the physician's contract termination date	Performance of the procedure as authorized

The MPN plan must also contain a continuity of care provision. The employer or insurer must provide for the completion of treatment, for employees being treated for an occupational injury or illness by a treating physician who is no longer a provider within the MPN. Should a provider leave the network, the employee has the right to request the ability to continue to obtain medical care from the same provider for a period of up to 12 months after the provider leaves the network based upon the type of medical condition. The completion of treatment shall be provided in accordance with the injured worker's type of medical condition, as described in the exhibit above.

The employer/insurer may require the provider to comply with the same contractual terms and conditions that were in place during the period of time the provider was in the MPN. If the terminated provider does not wish to comply with the defined continuity of care provisions, or does not comply with the previously agreed upon contracted services in the manner the insurer/employer authorizes, the employer/insurer is not required to continue with the terminated provider's services. If the terminated provider was terminated or not renewed for disciplinary cause, the employer/insurer is not required to provide for completion of treatment with that provider.

As a pre-condition, the entire MPN plan must be submitted for the Administrative Director's (AD) approval. The plan will be approved by the AD if it is determined that the plan meets the criteria within the MPN statute. The AD may not withhold approval or deny approval of the network plan based solely upon the makeup of the selection of providers. The plan must be acted upon by the AD within 60 days of submission or the plan is automatically deemed approved. Any economic profiling policies and procedures of physicians must also be documented and filed with the AD.

In practice, upon notice of industrial injury, the employer arranges for treatment at an approved MPN location. The employee must be notified of his/her right to change treating physicians within the MPN, and the means by which a list of participating physicians may be obtained. Should the employee disagree with the diagnosis or treatment proposed, second and third opinions must be sought from MPN providers using an appropriate specialty selection. After the first visit, the employee may select a physician of his/her choice within the network based on physician specialty or the physician's recognized expertise to treat the specific injury or condition. Specialty selections must also be made within network. Treatment by specialists

outside the MPN may be allowed on a case-by-case basis if the network does not provide the appropriate specialist and the employer/insurer approves.

If after three medical professionals have addressed medical treatment or diagnostic issues (initial treater, 2nd and 3rd opinions) and the employee is still not in agreement, an Independent Medical Review (IMR) process has been created for employees to resolve treatment decision issues. The AD will provide physicians to perform IMRs to include a review of all relevant correspondence and medical materials, a physical examination of the injured employee, and the ordering of any necessary diagnostics. The IMR's final determination will be based upon whether the disputed health care service is consistent with the most current UR guideline in place (currently ACOEM). The AD will adopt the opinion of the IMR, issuing a formal decision, and the employee then has the ability to obtain treatment or diagnostic services in keeping with the opinion of the IMR within or outside the MPN, at the employer/insurer's expense. No additional examinations or other reports will be admissible to resolve disputes arising out of care in the network plan. Conversely, if the employer disagrees with medical treatment or diagnostics provided by MPN physicians, they must use Labor Code Section 4062 to resolve these issues.

Findings: Medical Provider Network (MPN)

The formation of MPNs has occurred relatively recently so the effects of MPN participation are difficult to measure. Further, documentation on the part of carriers of claims on which MPN participation was occurring tended to be lacking. We tended to notice that an injured worker was in an MPN not when the claim was initiated but when the injured worker wanted to seek care from another provider who happened to be outside the network. In those instances, documentation existed showing that access to a non-network provider had been denied. In lieu of that, carriers would provide the names of providers within the network and within a reasonable distance from the injured worker's residence. In cases where this circumstance developed and injured workers were represented, applicant's attorneys typically did not challenge the selection process.

Carriers indicated that access to one or more Medical Provider Networks (MPN) was available to clients. As would be expected, the MPNs used are large, statewide networks details of which were available via website listings that are updated by the network provider.

None of the sampled cases included injured employee requests for 2nd or 3rd opinions, nor did we find issues surrounding employee pre-designation. Occasionally, there was confusion and conflict regarding the provider's participation in a particular MPN (a provider without knowledge of the MPN link, an out of date MPN list, etc.) This sometimes hindered the timeliness and effectiveness of medical services provided to the injured employee, but it was not a major factor in MPN cases.

Generally, we observed that claims with dates of injury in 2005 were managed through an MPN. We also noticed that when providers on pre-2005 claims were participants in the MPN that carriers advised them and their patients of this fact. Where very little activity was observed was in transfer of care cases. That is, carriers typically were making little effort to move claims where treatment was being provided by non-MPN providers. It seemed to us that this was a missed

opportunity. After all, if a transfer of care process is initiated and it leads to no objection then the transfer occurs without dispute. Even in those cases where an objection may occur, carriers could acquiesce to the objection thereby avoiding litigation on the matter. In defense of carriers, other medical management avenues (UR, treatment guidelines) exist as alternatives to transferring care.

A more detailed discussion of MPNs is contained later in this section.

Overview: AMA Guides

SB899 created a new schedule relying on the AMA Guides, 5th edition, to determine the percentage of permanent disability resulting from work injuries. Adjustment factors were to take into account the nature of the physical injury or disfigurement, the occupation and age of the worker, and the employee's future earning capacity. Importantly, the schedule was required to "promote consistency, uniformity, and objectivity." The previous schedule relied upon subjective factors and work restrictions, in addition to objective factors, to calculate a permanent disability rating. The goal was for adjustment factors in the new schedule to result in very similar disability ratings for similar types of injuries. To achieve this goal, two adjustment factors to assess permanent disability were significantly changed.

First, the employee's "diminished ability to compete" in the open labor market was replaced by the employee's "diminished future earning capacity." The formula to determine the factor for diminished future earning capacity was to be based on aggregate data regarding the average percentage of long-term income loss for several injury types, using the RAND Interim Report, December 2003, and other empirical data.

Second, "the nature of physical injury or disfigurement" in the schedule must incorporate both descriptions and percentage impairments contained in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, which replaced the percentage rating of subjective factors and work restrictions used in the previous schedule. Forty-one other states, the federal workers' compensation system, and several other countries use the AMA Guides to determine permanent impairment.

The schedule takes effect for injuries occurring on or after January 1, 2005. The schedule also applies to injuries before January 1, 2005 where there was no obligation prior to 2005 to comment on the existence or non-existence of permanent disability. The Administrative Director is required to review and amend the schedule at least once every five years.

Findings: AMA Guides

In our evaluation of carrier performance in this area, we were not looking to determine how much permanent disability costs may have declined as a result of the AMA Guides. Instead, we were looking to determine if carriers appear to be applying the appropriate schedule in their evaluation of permanent disability. In the sample, we observed 224 cases where injured workers were determined to have a reached a permanent and stationary status. Of that number, we

observed that carriers applied the correct schedule in 212 of those cases, or 95 percent of the time.

Exhibit III.16. Correct Application of Permanent Disability Rating Schedules				
Dates of Injury	**P&S**	**P&S and Old schedule apply**	**P&S and AMA Guides apply**	**Pursue correct schedule**
Pre-4/19/2004	117	107	10	114
4/19/04-12/31/04	71	28	43	62
Post-1/1/2005	36	0	36	36
Grand Total	224	135	89	212

Confusion about which schedule to use logically developed in the sample of claims with dates of injury between April 19, 2004 – December 31, 2004. This group of claims was more subject to uncertainty of which schedule would apply given the effective date (January 1, 2005) of the AMA Guides.

Overview: Apportionment of Permanent Disability

Effective April 19, 2004, for all dates of injury, apportionment of permanent disability (PD) is based on causation per Labor Code Sections 4663 and 4664. Labor Code Sections 4750 and 4750.5 regarding apportionment have been repealed. Physicians must now include a determination on apportionment and causation of PD, along with PD, for the report to be complete.

To make an apportionment determination, the physician must find what approximate percentage of the PD was caused by the direct result of the work injury, and what approximate percentage of the PD was caused by other factors both before and subsequent to the injury, including prior industrial injuries. If apportionment is not determined, the physician is required to state why a determination could not be made, and must consult with other physicians or refer the employee for a second opinion to make a final determination. Employees are required to disclose, upon request, all previous permanent disabilities or physical impairments.

The employer is only liable for the percentage of PD directly attributable to industrial injury. Prior PD awards are conclusively presumed to exist at the time of the subsequent injury. Labor Code Section 4664 allows 100 percent PD for each of seven body regions over an employee's lifetime:

a) Hearing.
b) Vision.
c) Mental and behavioral disorders.
d) The spine.
e) Upper extremities, including shoulders.
f) Lower extremities, including hip joints.
g) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in A-F above.

It is essential to determine the specific region of the body rated and what was rated to determine whether overlap exists between current disability factors and prior rated factors, as only overlapping disability can be factored out. Additionally, no PD rating for multiple injuries arising from the same work injury can be added together to exceed 100 percent PD. The provisions of SB899 do not constitute good cause to reopen or rescind, alter, or amend any existing order, decision, or award of the WCAB, including that of apportionment.

Findings: Apportionment of Permanent Disability

Of the 404 cases reviewed, 224 of them (55 percent) had reached a permanent and stationary status as of the review date. Of that sub-group of 224 claims, 69 claims (31 percent) had a documented prior award of permanent disability, or some documented pre-existing disability or condition resulting in a disability. Carriers were successful in seeking apportionment on 53 of these cases, or 77 percent of the time. This had the effect of reducing costs associated with permanent disability.

Of the 2005 injury cases reviewed, carriers were successful 100 percent of the time at recognizing and seeking apportionment appropriately, indicating consistent improvement since SB899 came into effect.

Exhibit III.17. Apportionment Outcomes

Dates of Injury	P&S	P&S w/Prior PD/award/condition	Percentage	Seek Apportionment	Percentage
Pre-4/19/2004	117	32	27%	23	72%
4/19/04-12/31/04	71	29	41%	22	76%
Post-1/1/2005	36	8	22%	8	100%
Grand Total	**224**	**69**	**31%**	**53**	**77%**

One other important finding here is that apportionment was successfully sought in nearly 24 percent (53 of 224) of the claims on which a PD exposure existed. This result suggests a robust increase from early industry estimates is possible in the number of PD cases on which apportionment may ultimately apply.

Exhibit III.18. Apportionment Outcomes

Injury Group	No. of PD Claims	No. With Prior Disability or Condition	# With Pursuit of Apportionment	Percentage of Cases Pursued
Pre-4/19/04	117	32	23	72%
4/19-12/31/04	71	29	22	76%
1/1/05+	36	8	8	100%

Another area we observed is whether carriers used the correct rating schedule when evaluating permanent disability exposure. We observed that in all but 12 of the 224 cases, the correct schedule was applied. The following exhibit provides those results.

Exhibit III.19. Correct Application of Permanent Disability Rating Schedules				
Injury Group	**# Of PD Claims**	**# With Old Schedule**	**# With New Schedule**	**# With Correct Schedule**
Pre-4/19/04	117	107	10	114
4/19-12/31/04	71	28	43	62
1/1/05+	36	0	36	36

In short, this data tends to show that carriers are pursuing apportionment and choosing the correct permanent disability schedule to resolve their liability.

There is still a significant amount of effort that must be generated to obtain apportionment in most cases. Determining the percentage of PD directly attributable to the industrial injury is not an exact science and may not be for years to come given the way in which PD was assessed under the old schedule and the difficulties that may exist in translating an award under the old schedule to the AMA Guides.

Furthermore, extracting the medical evidence in an admissible medical report from an untrained medical provider can at times be difficult, often requiring the extra expense of a second opinion or the use of an unwanted medical-legal dispute process. Inexperienced primary treating physicians, as well as seasoned disability evaluators, must contend with establishing disability attributed to pathology, asymptomatic and symptomatic pre-existing disabilities, retroactive prophylactic work restrictions, and evaluating disabilities under the AMA Guides that do not necessarily match with existing awards/ratings under the old permanent disability rating schedule.

Overview: Two-tiered Permanent Disability

The two-tiered permanent disability process applies only to employers with fifty or more employees. Pursuant to Labor Code Section 4658(d)(2), a new, tiered permanent disability benefit system provides for a change in the amount of permanent disability benefits an employee receives, tied to an employer's return to work offer. Employers who offer employees regular, modified, or alternate work within sixty days of permanent and stationary (P&S) status for a period of at least twelve months will pay a 15 percent decrease on each permanent disability (PD) payment remaining to be paid from the date the offer was made, regardless of whether the employee accepts or rejects the offer. Employers that do not make offers of regular, modified, or alternate work within sixty days of P&S status for a period of at least twelve months will pay a 15 percent increase on each PD payment remaining to be paid.

Labor Code Section 4658.6 defines the definitions of regular, modified, and alternate work as meeting all of the following conditions:

- Employee has the ability to perform the essential functions of the job.
- The job is a regular position lasting at least 12 months.

- The offered job provides wages within 15 percent of those paid to the employee at the time of injury.

- The job location is within a reasonable geographic commute from the employee's residence at the time of injury.

The employee may waive the reasonable geographic distance of job to residence requirement. It is deemed waived if the employee does not object within 20 days of notice of the right to object. The geographic distance is conclusively satisfied if the offered work is at the same location and same shift as the employment at the time of injury.

If the employer terminates the employment before the end of the period for which disability payments are due, even if the employee is discharged for cause, the remaining PD payments shall be increased by 15 percent and paid, restoring the original number of statutory weeks of payments. Employees who voluntarily terminate employment are not eligible for the 15 percent increase in PD payments.

Findings: Two-tiered Permanent Disability

For employers with 50 or more employees, the new two-tiered permanent disability benefit offers employers an opportunity to further reduce their PD liability by an additional 15 percent where timely offers are made that meet offer conditions that are defined in the statute. One data gathering difficulty we had was whether or not employers in the claim sample employed at least fifty people.

Given this uncertainty about employer size, we observed that in only 7 percent (1 of 14) of the claims where a 15 percent decrease could apply was it actually taken.

Communication between carriers and employers regarding return to work issues seemed to occur regularly; however, it does not seem to lead to the implementation of the two-tiered PD process as outlined by statute. Reasons for this appear to be:

- Failure to recognize the case as a 2005 date of injury with the associated benefit.
- Rote provision of permanent disability advances up to the full, anticipated award amount without a 15 percent withholding prior to permanent and stationary date.
- Failure to contact the employer timely to determine if the return to employment met the stipulated set of conditions.
- Inability to locate the employee to make the job offer within 60 days of the permanent and stationary date.
- Employee termination.
- Employer failure to decide if the employment offer will be made.

Conversely, where employers did not meet the 60-day offer timeframe, and injured employees did not return to work, few were paid the 15 percent increase in permanent disability payments.

The two-tiered permanent disability payment process is an area of law that appears to require closer scrutiny by carriers and better coordination between employers and carriers regarding return-to-work status following a determination of permanent disability. The current process appears to be having virtually no impact on the cost of permanent disability on claims with dates of injury on or after January 1, 2005.

Overview: Voucher System

Labor Code Sections 139 and 139.5 have been repealed, leaving the WCAB with sole jurisdiction of vocational rehabilitation issues effective 1/1/2004. For injuries on or after 1/1/2004, a Supplemental Job Displacement Benefit (SJDB), or voucher, replaces vocational rehabilitation services. Employees are entitled to a non-transferable voucher if their work related injury causes permanent partial disability (PPD) (i.e., a rating of 1-99 percent) and if they do not return to work for their employer within 60 days of the termination of temporary disability benefits. Both are conditions of voucher entitlement, replacing the previous eligibility status of "Qualified Injured Worker."

Labor Code Section 4658.6 states that within 10 days of the last payment of temporary disability, employers are required to provide the injured employee with a notice of the employee's voucher rights. The employer has 30 days to provide an offer of modified or alternate work. The employee has 30 days from receipt to respond to the offer, and 60 days to return to work. If the offer is made within 30 days and the employee does not return to work within 60 days, the employer is not obligated to provide the SJDB. Subscribing to the timeframes and the definitions of modified and alternate job modifications are key to determining liability:

Modified work – accommodating the injured employee's work restrictions, lasting at least 12 months.
Alternative work – meeting all of the following:

1. Employee has the ability to perform the essential functions of the job.
2. The job is a regular position lasting at least 12 months.
3. The offered job provides wages within 15 percent of those paid to the employee at the time of injury.
4. The job location is within a reasonable geographic commute from the employee's residence at the time of injury.

Should the employee be unable to return to work in a modified or alternate capacity, the voucher is structured to pay for education-related retraining or skill-enhancement, or both, at state approved or accredited schools. No more than 10 percent of the voucher money may be used for vocational or return to work counseling. Vouchers do not cover the costs of childcare, transportation costs, etc. The Administrative Director (AD) supplies the regulations governing the administration of the voucher benefit. Proof of service rendered and school accreditation should be required before paying vouchers. The amount of the voucher depends on the percentage of PPD awarded:

Exhibit III.20. Voucher Values Associated with Permanent Partial Disability Award Amounts	
Permanent Partial Disability Amount	**Supplemental Job Displacement Benefit (voucher)**
< 15 percent	Up to $4,000
15 percent - 25 percent	Up to $6,000
26 percent - 49 percent	Up to $8,000
50 percent - 99 percent	Up to $10,000

In the voucher system, employees receive no wage replacement (VRTD or VRMA). Only permanent disability benefits are payable. There is nothing in the current statute that prohibits settling the SJDB.

Since the repeal of Labor Code Section139.5 and Labor Code Section 4635 - 4647, there is no law to explain how injured employees with injury dates prior to January 1, 2004, will become eligible for vocational rehabilitation services (VR), or their ability to reinstate interrupted services. Absent clean-up legislation, *Godinez v. Buffets, Inc. and Specialty Risk Services* and *Pebworth* are followed as "ghost statutes" for the purposes of administering VR benefits:

For vocational rehabilitation claims prior to January 1, 2003:

1. VR declination - no entitlement to services
2. VR settlement - Thomas Finding at the WCAB where the issue of injury arising out of and/or in the course of employment is at issue

For vocational rehabilitation claims effective January 1, 2003:

1. VR declination - no entitlement to services
2. VR settlement - Thomas Finding at the WCAB where the issue of injury arising out of and/or in the course of employment is at issue
3. VR settlement - one time payment of up to $10,000, represented workers only
4. Self-directed VR plan contingent upon Rehabilitation Unit approval

Findings: Voucher System

Prior to the creation of the voucher system to manage vocational rehabilitation, injured workers were entitled to receive up to $16,000 in vocational benefits. Plan development costs did not count against the $16,000 cap.

With the voucher system, the extent of benefits is tied to the level of permanent disability on a sliding scale; the lower the permanent disability, the lower the voucher. For instance, injured workers with a permanent disability of up to 15 percent qualify for a voucher of $4,000. The voucher grows in $2,000 increments depending on the degree of PD up to a maximum of $10,000.

We observed that in cases where a voucher exposure existed and permanent disability had been determined that the carriers had correctly identified the exposure in their reserving practices. Further, carriers chose multiple approaches to resolve this benefit. In some instances, vouchers were used to pay schooling costs, while in other cases the voucher benefit was resolved as part of a settlement. Regardless of the approach, costs associated with vocational rehabilitation have declined significantly.

For claims with dates of injury on or after January 1, 2004, a Supplemental Job Displacement Benefit (SJDB), or voucher, replaces the old Vocational Rehabilitation system of services. The resultant claim costs associated with VR services have decreased dramatically, due primarily to the new conditions of the voucher entitlement. Where employers make timely offers of the pre-injury job or some form of acceptable permanent modified/alternate position, injured employees are ineligible for the voucher. Further, the value of vouchers in most permanent disability cases is likely to be limited to no more than $6,000 based on the notion that most permanent impairments under AMA Guides will amount to less than 26 percent. As such, the voucher value is a significant reduction to prior vocational costs that were subject to a $16,000 cap only after a formal plan had been developed.

The new statute contains notice requirements to injured employees with time deadlines. In the claim review sample, we observed 148 claims with dates of injury on or after 2004 claims where a notice requirement pertaining to voucher rights appeared to exist. In only 48 percent of the cases (71 of 148) was this requirement recognized. Where the initial rights notice issue is recognized, 79 percent are providing timely notices to injured employees. In only 31 percent of the cases were injured employees actually entitled to a SJDB voucher. Again, timely notice to the injured employee was issued only 46 percent (21 of 46 cases) of the time. Many files had no voucher entitlement notices at all.

Exhibit III.21. Notice and Voucher Offer Statistics

Dates of Injury	TD paid - notice apply	Notice need recognized	Notice sent timely	Require voucher offer	Voucher offer made timely
1/1/04-4/18/04	34	22	18	16	10
4/19/04-12/31/04	69	32	22	27	11
Post-1/1/05	45	17	16	3	0
Grand Total	**148**	**71**	**56**	**46**	**21**

Significant differences exist in the way carriers are managing the voucher entitlement process. Carriers either seem to be interested in settling the exposure once they know the degree of permanent disability, or they may only choose to pay vouchers in accordance with accredited schooling instead of settling the voucher exposure. In those instances where the voucher was settled, the value of the voucher associated with the level of permanent disability typically was included in the settlement.

In summary, the voucher system has led to a significant decrease in the cost of vocational benefits. Nonetheless, carriers need to improve their delivery of notices so injured workers

understand their benefit rights. Finally, the coordination of effective return to work programs between carriers and employers will lead to even lower costs associated with vocational rehabilitation.

Overview: Delayed Claims and the $10,000 Medical Cap

Effective April 19, 2004, when a claims form (DWC1) is filed, it is mandatory that medical treatment is provided to injured employees within one day of receipt of the DWC1. Treatment is limited to a $10,000 cap until liability for injury arising out of and/or in the course of employment (AOE/COE) is accepted or denied. The payment of this treatment does not presume employer liability for injury.

The employer must investigate and develop the factual situation to decide compensability within 90 days. Disputes that arise can be factual, legal, or medical. Where the employer delays a claim to make a medical causation determination, a medical report is required. The employer can rely upon the Primary Treating Physician's (PTP) opinion to make compensability determinations, provided the report is received within 14 days of the employer's date of knowledge of the claim. After that deadline, where the AOE/COE decision involves a determination of medical causation, a physician must be chosen from a panel of 3 Qualified Medical Evaluator (QME) physicians provided by the Medical Director (MD).

The employer may request the QME panel to determine AOE/COE, or if the employer delays or denies the claim, the employee may request a panel to determine AOE/COE. Unrepresented employees have the first chance to select the doctor from the assigned list. This is the only evaluation that can be obtained to resolve this issue. Unrepresented employees follow Labor Code Section 4062.1 to resolve AOE/COE issues, represented employees follow Labor Code Section 4062.2 for injuries on or after January 1, 2005.

Timely notice must be provided to the injured employee containing specific language describing the panel QME process, providing the actual QME Panel Request form, and attorney representation information for unrepresented workers. The employee is required to disclose all previous permanent disabilities or physical impairments. *Ex parte* rules control what information can be sent to the evaluating physician.

Until such time as AOE/COE is accepted or denied, authorized treatment provided must be consistent with the current UR guidelines in effect. Other evidence-based guidelines will not be entertained. Medical treatment includes reimbursement of medical and travel costs to employees. If a claim is ultimately denied, the employer has no ability to retroactively obtain reimbursement from its group health carrier for the treatment costs.

Findings: Delayed Claims and the $10,000 Medical Cap

The $10,000 medical benefit cap on delayed claims appears to have marginal to no significance on costs. Carriers indicated that they have attempted to speed up the compensability determination process, but we could not confirm that decisions were occurring on denied claims after 4/19/04 than they had been before.

We observed that 95 percent (73 of 77) of the compensability decisions were made within 90 days from the date the DWC1 was filed. Within the sample, 86 percent (66 of 77) of the claims had compensability decisions communicated within the requisite 90 days. Where decisions are delayed beyond the 90 days, it is generally due to lack of medical information from the medical evaluator, or lack of follow through on the part of the injured worker.

Conversely, all carriers avoid use of the unrepresented Panel QME process mandated by Labor Code Section 4062.1 for use during the delay period. Most carriers admitted that the unrepresented PQME process still had too many unresolved issues:

- Not enough panel evaluators available to make timely decisions
- Not enough qualified physicians on the regional panels
- Specialty needed not covered by the regional panel
- Biased evaluators in the regional panel
- Employee failure to release information compromising the outcome of the report

Exhibit III.22. Process Statistics on Delayed Claims

Dates of Injury	AOE/COE delay	Decision in 90 days	Denial in 90 days	Acceptance in 90 days	PQME offered	PQME overturned denial
Pre-4/19/2004	37	36	28	4	1	2*
4/19/04-12/31/04	23	20	15	4	5	2
Post-1/1/2005	17	17	10	5	1	1
Grand Total	**77**	**73**	**53**	**13**	**7**	**5**

* One injured employee was not offered the PQME, but located one through his independent efforts

As an alternative to the panel QME process, carriers generally are relying upon the Primary Treating Physician (PTP) or a Labor Code Section 4050 medical opinion to make medical compensability decisions. A PTP report obtained within the first 14 days of the delay period is admissible on the issue of compensability; thereafter, not. Occasionally, a specialist within the MPN was asked to address compensability after the 14-day timeframe, and the carrier relied upon the specialist's opinion without seeking agreement from the PTP. Very few delayed claim files contained specific language in delay notices that outline the PQME process or provide the PQME request form; rather, such notices described injured worker rights (i.e., access to the State Information and Assistance Officer to obtain this information, or how to solicit counsel). This circumvents the Panel QME medical legal process set up under Labor Code Section 4062.1.
Insufficient data was developed to adequately assess carrier practices on delayed cases with represented employees.

Unless the California Workers Compensation Institute and its members develop a consistent measure for determining how the $10K cap is influencing costs, it is not terribly likely that reliable data will be available across the industry to assess impact. Logic dictates that costs would go up marginally as a result of this statutory change.

Overview: Medical Legal Process

Effective 4/19/2004 for all dates of injury, the employer can no longer choose an AOE/COE evaluator, nor can either party choose an applicant and/or defense Qualified Medical Evaluator (QME) to resolve disputed issues. Panel QMEs will evaluate all disputed issues, including the issue of injury AOE/COE, unless the parties agree to an Agreed Medical Evaluator (AME) for represented employees. No disputed medical issue may be adjudicated unless there has first been an evaluation by the treating physician, a Panel QME or an AME.

Medical legal evaluation processes have been created to resolve disputes in the each of the following areas:

- LC4062.1 – unrepresented workers use the Panel QME process.
- LC4062.2 – represented workers use a Panel QME where the parties cannot agree on an AME effective 1/1/05; use LC4062 in the interim.
- LC4062(b) – second opinion spinal surgery process, effective 1/1/2004.

Disputes arising out of the utilization review process must be resolved initially using LC4610.

- Unrepresented workers

  If the employee is unrepresented, the employer may not seek the employee's agreement on, nor independently select an evaluating physician to resolve the disputed issue. Upon notice of a dispute (delay or denial), the employee has 10 days to solicit a panel of QME (PQME) evaluators from the Administrative Director (AD) to prepare a comprehensive medical-legal report. The employee selects the specialty at the time of the panel request. The employee chooses the physician from the panel of three provided within 10 days of panel receipt and schedules an appointment. The employer is to be informed of the physician selection and the appointment date. Unrepresented employees who fail to timely submit a PQME request, timely choose a panel physician, timely make an appointment, or provide timely notice to the employer lose their rights to select the evaluator. The employer may request the panel, select the physician specialty, select the evaluating physician, and/or set the appointment.

  The employer must provide estimated travel expenses to the employee prior to the evaluation date. During the appointment, the PQME must give the employee an opportunity to ask questions regarding the evaluator's background and the process. The employee is required to participate in the evaluation as requested by the evaluator unless there is good cause to discontinue. (LC4062.1 defines good cause to include evidence of bias, discrimination or a request to submit to an unnecessary medical exam or procedure.) If the employee declines to proceed with the evaluation for good cause, s/he is entitled to a new choice from a new panel of three QMEs. If the appeals board determines that the employee did not have good cause to suspend the first evaluation, the cost of the evaluation will be deducted from any award the employee may receive. If the employee later becomes represented, s/he may not obtain an additional evaluation to address the disputed issue.

- Represented employees

  Effective January 1, 2005, if the employee is represented and both sides cannot agree upon an AME to resolve the dispute within a 10-day period, which may be extended to 20 days by agreement, the evaluating physician must be chosen from a panel of three QME physicians provided by the AD. The party submitting the panel request to the AD identifies the specialty request of each party and the specialty of the treating physician, serving a copy of the request upon the opposing party. Within 10 days of receipt of the panel, the parties must attempt to agree upon a designated PQME. If the parties do not agree to a QME within that timeframe, each party may strike one name from the panel, with the remaining QME serving as the medical evaluator. If one party fails to exercise the right to strike a physician from the panel list within 3 days, the other party gains the right to choose the medical evaluator from remaining physicians on the panel list.

  The represented employee is responsible for arranging the appointment. Failure to notice the employer within 10 days of the PQME selection gives the employer the right to make the appointment arrangements, with notice to the represented employee. The employer must provide estimated travel expenses to the employee prior to the evaluation date. Represented employees who have received a comprehensive medical-legal evaluation addressing a dispute and later cease to be represented are not entitled to an additional evaluation.

- Second Opinion Spinal Surgery

  Where the employer objects to a treating physician's report recommending spinal surgery, the objection must be made within 10 days of the receipt of the treating physician's report. If the employee is represented, the parties may agree on the use of a licensed board-certified or board eligible orthopedic surgeon or neurosurgeon to prepare a second opinion resolving the disputed recommendation. If no agreement is reached within 10 days, or if the employee is not represented, the AD will randomly select an orthopedic surgeon or neurosurgeon to prepare the second opinion report. Examinations will be scheduled for the employee on an expedited basis, and the report will be served on all parties within 45 days of the initial receipt of the treating physician's report. If the report recommends surgery, the employer must authorize the surgery. If it does not recommend surgery, the employer may file for a hearing at the appeals board level. If the employee proceeds with the disputed procedure prior to completion of this evaluation process, the employer will not be liable for any medical treatment costs related to the disputed procedure, or for any period of temporary disability benefits resulting from the disputed surgery.

- Communication with medical-legal evaluators

  Ex parte rules control what information can be sent to the evaluating physician. *Ex parte* communication is prohibited. LC4062.3 allows records prepared or maintained by the treating physician(s), and medical and non-medical records relevant to the determination of the specific disputed issue. All information that a party proposes to be provided to the PQME must be served on the opposing party 20 days before sending it to the PQME. If the opposing party objects to the submission of any of the non-medical records, the records must not be sent to the PQME. If an AME is utilized, the parties will agree on the

information to be provided. All communication to the AME must be in writing and served on the opposing party 20 days in advance of the evaluation date.

The medical-legal evaluation report will summarize the medical findings on a form approved by the AD, and will be served on the parties. It will address all contested medical issues raised prior to the date of the evaluation. If either party subsequently objects to any new medical issue after the medical-legal evaluation is completed, the parties to the extent possible must utilize the same medical evaluator that addressed the prior disputed medical issue(s).

Findings: Medical Legal Process

From carrier interviews and a review of the claims data it appears that despite a legislative change in the medical legal dispute process, not much has changed in the actual process of managing claims. Carriers avoid the use of the Panel QME process. The PTP continues to be used to resolve disputes as a first level of defense.
There is still a carrier preference for the use of QMEs over the use of AMEs in represented cases. This may be more a function of an unwillingness to use AMEs as a definitive strategy to create room for negotiation as much as a practice in areas with high litigation rates.

Exhibit III.23. Medical Legal Process Results (Unrepresented v. Represented)

Dates of Injury	Unrepresented track	Issues to be resolved	Resolve issues w/PTP	Resolve issues w/PQME	Represented track	Resolve issues w/PTP	Resolve issues w/PQME	Resolve issues w/AME	Resolve issues w/QME
Pre-4/19/2004	56	54	27	16	95	4	2	20	69
4/19/04-12/31/04	69	64	44	14	50	7	1	12	31
Post-1/1/2005	52	49	41	3	15	4	1	6	2
Grand Total	**177**	**167**	**112**	**33**	**160**	**15**	**4**	**38**	**102**

Carrier Staffing: One final area to mention that was of interest in the claim reviews was whether carriers had added staff to respond to any new administrative responsibilities brought about by reform. To address this matter, the following questions were asked. Aggregated summaries of the answers to these questions are provided in italics.

1. Have you altered the caseload size of your claims staff as a result of reform? If so, how? *Carriers were uniform in their answers indicating that they had not altered the caseload size of their claims staff to respond to the demands of reform.*

2. For any in house medical professionals, have you altered their caseload at all? If so, how? *In general, carriers responded that caseload size had not changed. However, one carrier volunteered that some nurses now have no active caseloads as they focus exclusively on utilization review activities. That is, their assignments are short-term task specific. Medical issues are addressed on a particular claim in a single set of activities and then the medical management professional takes on a new task.*

3. Have you added medical or claims staff as a result of reform? If so in either area, by how much? *All carriers indicated that they had not added claims staff. However, carriers reported different staffing patterns with regard to medical staff. One carrier reported that they had added three Utilization Review nurses. Another carrier indicated that they had not added staff in house, but their contracted medical staff consisting of medical doctors, registered nurses, physical therapists and chiropractors had grown by nearly 300 percent. Another carrier reported that it had added no medical staff. A fourth carrier indicated that they had augmented medical management staff by about 30 percent.*

4. Do you rely more on outsourced UR services than you did prior to 1/1/04? If so, is this something you can quantify? *All carriers reported that outsourcing of services had increased. As noted in the responses to Question 3 above, one carrier indicated nearly a 300 percent increase in their external resource base. Another carrier reported that their outsourced services had increased by 800 percent to 900 percent. Two other carriers indicated that while more outsourcing had occurred they were unable to quantify the increase at this time.*

In short, reform has not influenced staffing decisions with respect to claims adjusting. However, carriers uniformly report that they have experienced a much larger demand for medical management services, chiefly in the area of utilization review, as a result of reform. Some carriers have taken on more of that staffing responsibility in house while others have outsourced medical management services to a much greater extent than had been done prior to reform.

DWC Audit Unit Results and Commentary

As part of the BRS study, a review of DWC audit results was conducted.

As articulated in AB749, the Division of Workers' Compensation Audit Unit commenced a new process for evaluating compliance with the state's workers' compensation statutes and regulations in 2003. The Audit Unit publishes its findings annually. The audits are of two types. The first, and most common, is the Profile Audit Review (PAR). The second, the Full Compliance Audit (FCA), is conducted on audit subjects who have failed to pass the PAR.

In its 2004 Audit Report Summary, DWC stated that, "The DWC continues planning, including rulemaking, within 2004 for the most recent reforms by the legislature within AB277 and SB228. These regulations will be promulgated and become effective in 2004 and early in 2005."

The DWC has only in the past two years begun this new approach to audits, and many of the laws are sufficiently new to make a seasoned assessment of claim performance a challenge. It is in this context that the following observations on the part of DWC staff should be considered:

a. More claim activities have been observed in the area of medical cost containment
b. The diminished availability of Qualified Medical Evaluators (QMEs) has led to conditional denials because evaluators may not be available within the 90-day time limit

c. Some companies seem to be trying to make early compensability determination as a way of avoiding payments on claims that are denied.

d. Denial rates are running on average at a fairly consistent rate of about 7 percent from year to year

e. Utilization Review was not well understood in the early part of 2004

f. Utilization review decisions did not necessarily match up against the payment of medical bills suggesting that the medical management and bill review staffs were not fully integrated

g. The Audit Unit has received some complaints that companies have been trying to apply chiropractic and physical therapy caps to claims with dates of injury prior to 1/1/04

h. Little information exists on Medical Provider Networks

i. Some carriers/administrators may be jumping the gun in trying to get their own QMEs before the 15-day period has elapsed (ten days for the injured worker to make an election and five days for mailing)

j. Many aspects of reform are too early to evaluate, or they have not yet been the subject of DWC audits

DWC Audit Subject Results

Several observations on the part of DWC staff are similar to the study team's findings following claim reviews at carrier claim offices.

Before proceeding with claim review information, key DWC Audit Unit findings from 2003 and 2004 are summarized.

1. There were 490 claims audited in 2003 on which unpaid compensation existed. The amount unpaid amounted to $370,000. In 2004, unpaid compensation was found to exist on 559 claims totaling $635,000.
2. The Audit Unit reported on the frequency of violation measures for the five key areas under review for audits where the subject company passed the Profile Audit Review (PAR) criteria. Results for 2003 and 2004 are displayed in the following exhibit.

Exhibit III.24. DWC Violation Findings

Subject Area	2003	2004
Unpaid Indemnity	13.24%	12.02%
Late First TD/Salary Continuation Payment	24.57%	24.59%
Late First PD, VRMA, Death Benefit	14.03%	12.03%
Late Subsequent Indemnity Payment	25.37%	20.39%
Notice Issues Re: AME/QME and VR	27.78%	24.16%

3. The Audit Unit also reported in summary fashion for 2003 and 2004 its pass/fail results for the PAR and FCA. Those results are contained in the exhibit below:

Exhibit III.25. Number of Audit Subjects/Results by Group		
	2003	2004
Audit Subjects	**70**	**48**
Number/Percentage Meeting PAR Criteria	65/92.9%	37/77.1%
Number/Percentage Meeting FCA - Stage 1	4/5.7%	5/10.4%
Number/Percentage Failing FCA - Stage 2	1/1.4%	6/12.5%
Total	**70/100%**	**48/100%**

Observations on DWC Audit Findings

Aggregate data from year to year as displayed in the first exhibit tends to show slightly better performance in 2004 in the compared categories of performance. Slightly fewer instances of unpaid indemnity occurred. And with the exception of the timely delivery of the first temporary disability payment or first salary continuation payment (where results were almost identical from 2003 to 2004), all areas of performance were better in 2004 than in 2003.

However, when comparing the pass/fail results for 2003 to 2004, the 2003 results are much more favorable. In 2003, nearly 93 percent (65 of 70) of all audit subjects passed the PAR while in 2004 that number slid to 77 percent (37 of 48). Further, only one of the seventy 2003 audit subjects failed the FCA, while in 2004 that number had grown to six, or one of every eight audit subjects. It also means that slightly more than half the 2004 audit subjects who failed the PAR did not pass the FCA. By contrast, in 2003, only one of five failed the FCA. The 2004 results are tempered somewhat by virtue of the somewhat stringent criteria to pass the PAR. Lower scoring criteria as reflected in the exhibit above actually created a higher performance standard for 2004. As such, fewer audit subjects were able to pass the PAR.

Analysis of the Impact of MPNs

The workers' compensation reforms of 2003 and 2004 highlighted the potential role that networks of physicians, hospitals and other providers could play under certain circumstances in containing medical claims costs of injured workers in California and insurance carrier premiums. These networks, designated medical provider networks (MPNs) in SB 899 (Chapter 34, 2004), were to be chosen by carriers, including self-insured employers—the payers. The goal was to have networks of medical services providers that would provide access, quality, and choice on a cost effective basis to policyholders' employers when they are injured on the job. MPNs are quite similar to preferred provider organizations (PPOs), entities that are usually unregulated in the marketplace. PPOs have played a key role in the California workers' compensation marketplace since the early and middle 1990s and have played a major transitional role in the general healthcare marketplace since the early 1980s. The intent of the reform legislation was that MPNs--consisting of restricted and specified numbers of qualified physicians, clinics, and hospitals--could help reduce the medical portion of workers' compensation claims cost through fee discounts, improving utilization review and management (UR/UM), primary provider, and referral channeling and shifting the balance of medical control toward carriers, self-insured policyholders, employers and their designees.

During 2005, there was a rush in MPN applications to the DWC. At least 973 applications were approved by mid-October 2005. Some additional ones have been approved during November and December 2005. A significant number of additional applications are expected in 2006.

Much of the workers' compensation employer marketplace has already been covered by MPNs. According to some experts that BRS surveyed, probably over 70 percent of California's workers are employed by firms covered by MPNs. Some additional workers are in existing PPOs that have not been qualified as MPNs or in health care organizations (HCOs) that have not as yet converted to MPN status.

Approach to Analysis

During much of 2005, there were numerous indications that workers' compensation premiums and medical claims costs were declining precipitously. Our goal was to determine if MPNs have played a role in those declines. We also sought to answer such questions as: To what extent are MPNs parts of, or linked to, other multi-product organizations? How many MPNs are there in the workers' compensation market? What is the MPN "market share"? Have physicians accepted MPNs and how oriented are they to the MPN provisions in the reforms?

Due to time constraints and the relative newness of the regulatory implementation phase that California is in, BRS cannot fully address these (and related) issues at this time. However, we have approached these issues in a preliminary fashion by conducting of a survey of some of the key participants in the MPN development and implementation process, including senior PPO and MPN executives and PPO/MPN consultants, and experts (the BRS PPO/MPN Experts Survey).. We also interviewed some respondents in greater depth, in order to enhance our early sense of the macro-impact of the reforms on the PPO/MPN side of the workers' compensation marketplace.

As implementation of the MPN reforms proceeded, BRS identified a number of questions:

- How and in what circumstances did so many MPN applications come in? What are the characteristics of these applications?
- How much of the employer market do they cover?
- How customized to payer requirements are MPNs?
- How many employees are covered by MPNs? What market share has been attained by MPNs?
- How are MPNs linked to PPOs? To health care organizations (HCOs)?
- Are MPNs (and their predecessor organizations PPOs and/or HCOs) parts of, or linked to multi-product organizations--cost containment organizations (CCOs)--with UR/UM, case and disability management (CM, DM), bill review (BR) and/or third party administration (TPA) product lines? How "bundled" are these offerings?
- How familiar are MPN providers with the various reform-linked UR/UM, CM, DM guidelines and standards?

- How concentrated is the MPN portion of the workers' compensation market?
- To what extent have MPNs and/or CCOs already "taken over" employer-carrier medical control over workers' compensation cases.
- Have MPNs contributed to the considerable reduction in premiums and economic cost of workers' compensation? If so, how much?

Linked to the last question, we also sought to address several related questions, in terms of the rank and relative impact of the following factors on reducing economic cost of medical claims and premiums:

- Adoption of ACOEM and other UR/UM guidelines
- Implementation of tighter UR/UM implementation policies
- Dramatic reductions in PT and chiropractic visits
- Stricter disability definitions and policies
- Adoption of mandatory fee schedules and reductions in provider rates
- Roles of anticipated premium cuts and public jawboning
- Changes in the role of attorneys
- Changes in the volume and rate of workers' compensation cases

While BRS can only partially address these questions at this time, given how early California is in the MPN implementation process and given the relative scarcity of data available from public sources, we did begin to address these and related questions on a preliminary basis. We did so based on the following:

- Partial review of publicly available MPN filing information from DWC
- Development and conduct of a survey with a selected group of twenty (20) PPO/MPN executives and PPO/MPN consultants (BRS Survey of PPO/MPN Experts)
- Selected PPO/MPN questions in the BRS Employer Survey
- In-depth review of marketplace developments with a subset of PPO/MPN Expert Survey respondents

We conducted an extensive though partial review of MPN information available from DWC, including summary listings and a few full MPN filings. The most recent information available from DWC was dated October 18, 2005. There have been changes since that date but these were not readily available. We decided that for the purposes of the current BRS analysis, it would be appropriate to conduct a telephone survey using a more or less standard questionnaire format. The proposed (and resulting) sample size was 20 respondents, representing or associated with MPNs, whose business locations were more or less spread evenly among the Bay Area, Los Angeles, San Diego, and Sacramento areas. Eleven (11) are executives with PPO-MPN organizations; nine (9) are PPO/MPN experts/consultants and/or executives with associated CCOs with PPO, MPN and/or HCO product lines. Most respondents were interviewed once; seven (7) were interviewed at least twice and four (4) of those were also interviewed at some

additional depth concerning all aspects of workers' compensation and PPO/MPN marketplace developments.

A copy of the PPO/MPN Expert Survey Questionnaire is attached as Appendix E.

For the purposes of the PPO/MPN analysis, we also added several questions to the BRS Employer Survey, focusing on types of network choices available to employees and employers (PPO, MPN, HCO) by type of payer. From the more in-depth discussions with some expert respondents, we obtained extensive qualitative insights into some MPN market share developments, information on some other MPN-PPO-CCO linkages, magnitudes of employer impacts, and some related matters. In particular, we focused on rough estimates of the actual size of the MPN sub sector of the workers' compensation marketplace and the comprehensive impacts of multi-service CCOs and MPNs on costs and premiums.

Organizational Types and Regulatory Authority

MPNs as defined in SB 899 are intended to be vital components of the overall workers' compensation reform package. Their apparent purpose is to enhance the cost effectiveness of medical services within the workers' compensation system and to do so while facilitating utilization management and quality of those services. MPNs are linked in the legislation to strengthened utilization review/utilization management (UR/UM) and associated "evidence-based" clinical guidelines, in part through the mandating of the (ACOEM) and related guidelines.

PPOs

From economic and organizational perspectives, MPNs are not significantly different from PPOs, as commonly defined for either the general health care or workers' compensation marketplace. PPOs and MPNs are networks of doctors, hospitals, clinics, and other medical providers where access for payers and their insureds to those providers is guaranteed by contract, typically at established fee schedules and/or established fee discounts. There are some permutations of that basic model having to do with how tightly knit the providers are to the PPOs and how the fee schedules and discounts are determined.

In California, on the health care side, PPOs as entities usually are not directly subject to regulations, except insofar as they are parts of existing insurance products, and thus indirectly are regulated by the CDI. Some health plans (HMOs) permit some of their PPO-like product lines to be directly regulated by the California Department of Managed Health Care (DMHC). In neither case, however, are PPOs regulated as separate, specific health care entities. Under the workers' compensation reforms, MPNs appear to be in effect "relabeled" PPOs for the workers' compensation marketplace, specifically subject to DWC regulations in terms of initial qualification of the networks and maintenance of certain minimum provider standards. PPOs have been active in workers' compensation for some time, in particular since the early 1990's.

Some PPOs active in the workers' compensation market, and hence MPNs, are linked to, or are parts of health plans (HMOs) that are partially regulated by DMHC. In addition, many MPNs are parts of, or closely linked to, management companies directly linked to and/or parts of cost

containment organizations (CCOs), management firms or brokerage firms with multiple cost containment product lines such as bill review (BR), utilization review and utilization management (UR/UM), case management (CM), disability management (DM) product lines. Such firms also often have third party administration (TPA) product lines. Typically these CCOs are not directly regulated by state or federal agencies. In California's workers' compensation marketplace, CCOs are usually only regulated for their MPN and/or their healthcare organization (HCO) product lines.

HCOs

HCOs are entities also regulated by DWC. They are well-integrated entities similar to HMOs on the general healthcare side, with extensive control over enrollees-insureds, direct responsibility for cost containment services and considerable consumer and fiscal reporting requirement. HCOs were originally enabled during the mid-90s, but have not successfully captured the market on the workers' compensation side. It is not clear why HCOs have not been more successful in the California market. Some industry experts have indicated this may be due to complex regulatory and compliance requirements and cost of development and ongoing operations.

Recent PPO/MPN Market and Regulatory Developments

During early and middle 2005, from the news media as well as comments from consultants and experts in the workers' compensation marketplace in California, BRS gained preliminary insights into some possibly key developments related to PPOs and MPNs in California. There was considerable "background noise" during this period suggesting that workers' compensation medical claims costs and associated premiums were declining significantly. Some suggested that MPNs had played a role in that decline, even though regulatory implementation was just starting up. But there was little indication of how that role may be playing out, and how the multi-product nature of CCOs impacted that role. There were also indications that the new MPNs were in many instances repackaged versions of the old PPOs and/or HCOs. Some observers of the workers' compensation marketplace and those familiar with aspects of the reform legislation suggested that a rather large number of MPNs were going through the qualification process at DWC and obtaining approvals rather expeditiously, partly because of that repackaging. Some mentioned that well-established HCOs and large California-wide and nationwide PPOs and associated CCOs were quickly responding to the opportunities offered by SB 899 and setting up numerous MPNs jointly with workers' compensation carriers and self-insured employers. A significant number of these MPNs were parts of much larger entities, cost containment organizations (CCOs) or HMOs, firms with multiple cost containment products and services. There were indications that the new MPNs were, at least potentially, in their relations to payers, to some extent "bundled" with some other cost containment services.

During much of 2005, in the wake of passage of the workers' compensation reform legislation in 2003 and 2004, there was a dramatic rush of applications for MPN status to the DWC of the California Department of Industrial Relations (DIR). This has slowed down some in the Fall of 2005 but may be picking up again in early 2006. These applications came from payers, that is, workers' compensation insurers typically acting jointly with insured and self-insured employers. And both types of applicants specified in their applications the names of the MPNs. In most applications the names of related owning or linking organizations, cost containment

organizations (CCOs), are also listed. The latter have at least one of the following product or service lines: health insurance brokerage, PPO, HMO, utilization review/utilization management (UR/UM), case management (CM), disability management (DM), bill review (BR) and/or third party administration.

According to some PPO/MPN experts, there are approximately 5,000 employers in California, fully insured and self-insured, who are "eligible" either directly or indirectly to receive MPN services if so qualified by DWC. About 40 percent of these employers are covered by the State Compensation Insurance Fund (SCIF). About 1,000 of them are self-insured employers, a significant portion of them public agencies. According to DWC, as of mid-October 2005, 973 MPN applications have been received, reviewed, and approved by DWC. Most, about 62 percent, applications have come from workers' compensation insurers and 38 percent from private and public self-insured employers. An estimated 60 additional applications have apparently been approved by DWC through December 2005. An estimated 200 applications have apparently been received by DWC but have not as yet completed the application process, of which about 30 are from self-insured employers. Approximately 300 to 400 material modification applications are likely to be received during the next six months or so, depending in large part on how many payers decide to shift from one MPN to another, how many payers decide to make changes in their network composition and proceed down the road to MPN customization and how many new payers decide to initiate the process. An estimated 200 to 300 "new" self-insured employers and fully insured employers-carriers may decide to go through the application process to customize the MPNs during the current calendar year.

Whether employers and carriers choose to establish MPNs as one element of a strategy to contain medical claims costs is discretionary according to SB 899. Clearly benefit-cost factors play a critical role. One key advantage of the MPN option to workers' compensation payers is that the length of time of employer control is increased from 30 to 60 days. Another advantage is that it affords employers an additional opportunity to obtain fee discounts from physicians and other providers for provision of medical services to workers' compensation insureds. Within the framework of the reform legislation, DWC is the regulator of MPNs. It directly regulates the payers of workers' compensation insurance coverage and services, that is, carriers and self-insured employers. Hence, DWC indirectly regulates MPNs through its authority over payer. MPNs are primarily regulated through the application approval authority, which extends to major changes to existing applicants, also known as material modifications.

So far, it appears that fully insured workers' compensation carriers have covered a relatively larger portion of their insured population with MPNs than have self-insured employers. So far the majority of self-insured employers, in particular in southern California, have eschewed exercising the (discretionary) MPN option. They may have done so because these employers are relatively satisfied with their current sets of medical service providers, and/or it may be an additional excessive financial burden to form an MPN and get it qualified. Many of their provider networks are in currently unregulated but formal PPOs or informal networks explicitly customized to individual employers. The physicians and clinics therein may not be otherwise willing to accept additional discounts (or withholds) and the self-insured employers may not be interested in additionally antagonizing their providers. So far then some insured and most self-

insured employers have decided to remain with their current providers and have elected not to take advantage of additional employer control and/or the further provider discount opportunities.

Have MPNs affected HCOs? Workers' compensation health care organizations (WCHCOs, HCOs) were modest but key players in the managed care component of California's workers' compensation marketplace before 2004, besides unregulated PPOs. HCOs are heavily regulated by DWC, and are in effect integrated "HMO-like entities" targeted to workers' compensation payers; they include a full range of internalized utilization review and management, disability and case management, bill review, return to work, financial and consumer control and other health plan-like features. They are "fully bundled" service organizations, though they typically retain fee-for-service payment methodologies. They have the capacity to do capitation payment, but in recent years have avoided doing so. All of the major PPOs and some of the CCOs have licensed HCOs as parts of their product lines.

It appears that most HCOs in California over the past year have been turned into MPNs. In effect, the parent owning the CCOs have exchanged expensive, heavily regulated product lines for less expensive, less regulated product lines that nonetheless have greater potential medical control over workers' compensation cases. With the passage of SB 899, the state gave employers, in effect, an approach to increasing employer control over workers' compensation cases by substituting relatively unregulated and "looser" MPNs for heavily regulated and fully bundled and integrated HCOs. MPNs are relatively less expensive to develop or lease as well. In addition, since most of the MPNs so far certified by DWC are parts of CCOs and HMOs with more or less full arrays of cost containment product lines, the opportunity to increase revenue through increased UR and UM arose. This latter is the case even if adoption of the ordinary medical fee schedule (OMFS) and the chance to include fee discounts did not lead to price savings.

The role(s) of physicians and allied health professionals in MPNs and PPOs are critical to the success of MPNs. BRS did not have the time and resources to adequately address the role of physician and health professionals from clinical, actuarial, and/or economic perspectives. There are initial indications that physicians and clinics reportedly are not satisfied with the newly adopted and enforced workers' compensation provider rates. They believe that bill review service charge discounts are not specifically included in their contracts. A considerable number of physicians apparently are not aware that they are in specific MPNs, or that they have agreed to specific discounts. Physicians complain about additional paperwork requirements and apparent considerable delays in payment. Many apparently have not been made aware of their full responsibilities under the workers' compensation reform legislation. Many have not been trained in the ACOEM and related UR/UM guidelines. It is possible that many providers included in PPO/MPN listings provided to DWC have not been specifically trained in workers' compensation regulations, guidelines and other requirements and are not clear about their MPN responsibilities.

Some Initial MPN Findings

BRS prepared initial findings based on the information gathering process identified in the previous section. They are initial in the sense that considerable additional research and surveys

would need to be conducted after somewhat more time has passed before the resulting findings can be regarded as definitive. Further, the PPO/MPN Experts Survey and the associated in-depth interviews are from very small "focus groups," which may or may not be representative of the PPO/MPN industry. Hence, there may be some reporting bias in that survey. The initial findings are as follows:

- BRS estimates that currently about 75 percent of all covered workers are covered by insurers and employers who have already selected MPNs and/or whose applications are in process at DWC. Some remaining workers are with employers who already access a PPO for workers' compensation services and/or in HCOs that have not yet gone through the certification process. Some employers still identify their qualified network as a PPO not an MPN (In-Depth Interviews).
- MPNs have rapidly penetrated the workers' compensation market. Roughly 25% to 30 percent of self-insured employers have designated qualified MPNs. It is estimated that about 80 percent to 85 percent or more of fully insured employers make qualified MPNs available to their employees. The insured employers have made greater use of the discretionary MPN option than have self-insured employers. These percentages are not exact, partly because DWC does not as yet have specific data reports MPN application information to enrollment information by employer and carrier.
- 82.5 percent of California employers have selected an MPN, PPO, or HCO. It is likely that the HCOs mentioned in this Survey have already transitioned to MPN status. It is also possible that respondents did not make clear distinctions between the previously unregulated PPOs and MPNs. Relatively larger firms are more likely to have already submitted applications to DWC, so there may be a small bias at work here (refer to the exhibit below).

Exhibit III.26. Workers' Compensation Network Offerings by Type by Employer and Payer, California 2006

Type	PPO	Percent	MPN	Percent	HCO	Percent	Other	Percent	Total	Percent
CA State Compensation Insurance Fund (SCIF)	100	37.74%	66	24.91%	46	17.36%	53	20.00%	265	28.84%
Insurer other than SCIF	171	33.86%	189	37.43%	77	15.25%	68	13.47%	505	54.95%
Individual Self-Insurance	16	28.07%	23	40.35%	8	14.04%	10	17.54%	57	6.20%
Group Self Insurance	25	34.25%	22	30.14%	13	17.81%	13	17.81%	73	7.94%
Other--Public Agency	7	36.84%	4	21.05%	0	0.00%	8	42.11%	19	2.07%
Total	319	34.71%	304	33.08%	144	15.67%	152	16.54%	919	100.00%

Source: Ibid. Cell numbers refer to frequency of employers. Total respondents, 919.

- Out of 973 applications, 35 percent or 341 applications came from the top 20 private carriers and self-insured employers. From the perspective of employers dealing with insurers, the "application" market does not appear to be excessively concentrated. This may also be an indication of increased competition related to market entry into the workers' compensation insurance market refer to exhibits below.

Exhibit III.27. DWC Applicants by Payer Type		
Type	**Number**	**Per Cent**
Workers' Compensation Insurer	601	61.77%
Self-Insured Employer	337	34.64%
Joint Powers Authority	33	3.39%
State	2	0.21%
Total	973	100.00%

Source: California Department of Industrial Relations, Division of Workers Compensation, "Medical Provider Networks Approved by DWC," (MPN Listing), October 18, 2005.

Exhibit III.28. Top 20 Private Workers Comp Insurer-MPN Applicants, California, October 2005		
Workers' Compensation Insurers	**Number**	**Per Cent**
Fidelity and Guaranty Insurance Underwriters,	45	4.62%
ACE American Insurance Co.	35	3.60%
Zurich American Insurance Company	31	3.19%
New Hampshire Insurance Company, Ltd.	28	2.88%
American Home Assurance Company	22	2.26%
Discover Property & Casualty Insurance	19	1.95%
United States Fidelity and Guaranty	19	1.95%
St Paul Fire & Marine Insurance Company	24	2.47%
Old Republic	16	1.64%
National Union Fire Insurance Co. of	15	1.54%
Commercial Casualty Insurance Company	13	1.34%
Travelers Casualty Insurance Company of	12	1.23%
The Insurance Company of the State of	14	1.44%
American Zurich Insurance Company	10	1.03%
Granite State Insurance Company	10	1.03%
Hartford Underwriters Insurance Co.	10	1.03%
Landmark Insurance Company	10	1.03%
AIU Insurance Company	9	0.92%
Continental Casualty Company (CNA)	9	0.92%
Safety National Casualty Corporation	10	1.03%
Other	612	62.90%
Total	**973**	**100.00%**

Source: Ibid.

- SCIF, the largest workers' compensation carrier, had submitted only seven (7) MPN applications to the Division of Workers Compensation (DWC). A significant proportion of SCIF's employer clients--about 80 percent--are in situations where SCIF has made available to them an MPN. Evidently, SCIF groups its employers into "pools" to whom the same MPNs are offered. SCIF developed its own MPNs recently placed into legal question but primarily uses MPNs from Kaiser, Kaiser On-the-Job, and the Blue Cross Prudent Buyer PPO. In terms of covered employees in California, this combination of networks probably constitutes the largest MPN in the state. However, recently SCIF has taken steps to decertify its MPNs.
- MPN applications to DWC are concentrated among a relatively small number of PPOs and CCOs. The top fourteen (14) PPOs/CCOs submitted 815 or 83.8 percent of 973 MPN applications. We have excluded from this count organizations that are invariably and exclusively linked to one of the other MPNs, and/or lease networks from other MPNs,

PPOs, or CCOs. These latter include brokers such as Frank Gates or Gallagher-Bassett, or insurers such as ACE and Discover Re. Any remaining joint ventures such as Kaiser with Prudent Buyer and InterPlan are weighted appropriately in the summations. (Refer to Exhibit III.23. below.)

- The MPN "market" is highly concentrated. The top six (6) PPOs/CCOs submitted 721 or 74.1 percent of all applications. They include in rank order of number of applications submitted: First Health (292, or 30 percent), Prudent Buyer of Blue Cross of California (Wellpoint) (117 or 12.4 percent), Concentra (111), CorVel (79), Crawford (64) and Sedgwick (43). ACE and Discover Re's applications can be included in this total, as their MPNs are distributed among First Health, Concentric, and CorVel. This level of concentration, though not weighted by employees-insureds, might be an indication of heavy market concentration. (Refer to Exhibit III.23. below.)
- The remaining eight (8) PPOs/CCOs among the top 14 submitted 117 applications or 10.6 percent of the total. They include, in order of applications submitted: Liberty Mutual, WellComp, MedEx, IntraCorp, InterPlan, Kaiser, State Fund, and SafeCo. (Refer to Exhibit III.23.)

Exhibit III.29. Top 16 MPNs, California, October 2005

MPNs	Number	Per Cent
First Health/CompAmerica	292	30.01%
Prudent Buyer/Blue Cross of CA	117	12.02%
Concentra/FOCUS/Beech St.	111	11.41%
CorVel	79	8.12%
Crawford	64	6.58%
Sedgwick	43	4.42%
Liberty Mutual	25	2.57%
WellComp	23	2.36%
MedEx	18	1.85%
IntraCorp	16	1.64%
InterPlan	15	1.54%
Discover Re	8	0.82%
Kaiser	8	0.82%
State Fund	7	0.72%
ACE	7	0.72%
SafeCo	5	0.51%
Other	135	13.87%
Total	973	100.00%

Source: Ibid. Notes: ACE is linked to First Health; Discover Re, to Concentra; Frank Gates, Cambridge and Gallagher-Bassett are brokerage firms linked to Concentra and CorVel and are included in their totals.

- These MPNs were also previously relatively unregulated PPOs, all are multi-product CCOs, all have to one degree or other, UR/UM, CM, DM, BR and TPA capabilities, for either the general health care and/or workers' compensation markets and all have HCO licenses. In effect, then, MPNs can serve as "loss-leaders" for related or joint (bundled) services (PPO/MPN experts Survey).

- Out of the top eight MPNs, Liberty Mutual, State Fund and SafeCo are primarily carriers; Kaiser is an HMO; WellComp and MedEx are California-based MPNs and CCOs; and Liberty Mutual, SafeCo, IntraCorp and InterPlan are organizations based outside California. WellComp, MedEx, Kaiser, IntraCorp and InterPlan have HCO licenses (PPO/MPN Experts Survey). All of the entities with HCO licenses can usefully be regarded as multi-product CCOs with respect to the workers' compensation market (PPO/MPN Experts Survey; In-Depth interviews, Internet).
- One way of characterizing PPO/MPNs is by the reported numbers of providers listed nationally and statewide. Some estimates including both physicians and certain allied health professionals for eight of the top fourteen MPNs are as follows:

    1. First Health (CompAmerica): 462,000 providers nationwide, 70,000 in California
    2. Prudent Buyer: 200,000 nationwide, 43,000 in California
    3. Concentra (FOCUS, Beech St): 450,000 nationwide, 42,000 in California
    4. CorVel: 50,000 nationwide, 6,000 in California
    5. Sedgwick: 20,000 in California
    6. WellComp: 3,700 in Southern California
    7. MedEx: 3,000 in Southern California
    8. InterPlan: 15,000 in California

    There may be some duplication of provider names within these MPNs, especially with First Health, Concentra and Sedgwick. There is of course very substantial duplication of the various networks operated by First Health, Prudent Buyer, Concentra, Sedgwick and, presumably, Crawford (In-Depth Interviews, Internet).
- The larger MPNs in terms of applications submitted and network size--First Health, Prudent Buyer, Concentra, Sedgwick and InterPlan-- blanket California with their networks. Some experts indicate that only about 5,000 to 7,000 providers, appropriately allocated among specialties, are needed to cover California. Apparently most PPOs/MPNs are not specifically customized to individual carrier and employer requirements. "Geomapping" and constrained web selection are sometimes offered as customization options to carriers and employers, whereby the latter in effect get to create their own "real" provider networks. It is not clear how such huge networks enhance provider quality (In-Depth Interviews, BRS PPO/MPN Experts Survey).
- Although almost all MPNs are parts of larger CCOs with multiple product lines, only 55 percent of PPO/MPN experts indicated that MPNs are parts of more or less fully bundled packages directly linking networks to UR/UM, CM, DM, BR and/or TPA services. Most respondents, 75 percent, indicated that MPNs and/or affiliated CCOs had adopted ACOEM and related UR/UM guidelines and mandatory provider schedules and maxima (BRS PPO/MPN Experts Survey;).
- Most respondents (60 percent) noted that affiliated CCOs have de facto medical control over injured workers. The implication in practical terms is that the UR/UM product lines

of CCOs are in most instances effecting "most" medical control over injured workers. (BRS PPO/MPN Experts Survey)

- Most respondents (65 percent) believe the DWC review process has not been difficult to navigate. Some believe that the process has focused perhaps too much on certain paperwork requirements and not enough on "network viability" and provider quality. They also believe that there should be some regulatory oversight of linked CCOs. Some maintain that DWC for this review activity is perhaps understaffed (In-Depth Interviews; BRS PPO/MPN Experts Survey).
- Most respondents believe that insufficient attention has been paid to workers' compensation qualifications of physicians MDs in the MPN networks. They recognize that the legislation permitted grandfathering of HCO networks and provider qualifications. Almost all respondents hold that MPN providers have not as yet been adequately trained to meet the new ACOEM and other UR/UM guidelines (80 percent) and/or the Disability and Apportionment requirements and standards (90 percent) (BRS PPO/MPN Experts Survey; Exhibit)
- Some respondents maintain that HCO requirements and regulatory processes are more cost-effective and viable in long run than MPN requirements. They also maintain that they are more equitable, are more transparent, allow for more customization of networks to payer and employee requirements. Some respondents believe that MPNs may become more like HCOs in the near future (In-Depth Interviews, BRS PPO/MPN Experts Survey).
- Most MPNs and their affiliated CCOs, and specifically that is their bill review entities have explicitly included the current state fee schedules in their provider agreements and procedures (75 percent). Most MPN provider agreements have incorporated these fee schedules by reference. However, some respondents mentioned that it is not clear that individual providers are fully aware of the new fee schedules and discounts (In-Depth Interviews, BRS PPO/MPN Experts Survey).

Exhibit III.30. PPO/MPN Experts: Selected Survey Questions
October 2005-January 2006

Survey Question/Response	Y	N
1. Are PPO/MPNs affiliated with CCOs?	80%	20%
2. Are MPNs part of bundled service packages	55%	45%
3. Is the MPN a statewide or large regional network?	55%	45%
4. Are MPNs "customized" to payers?	50%	50%
5. Do MPNs and/or CCOs have medical control over employees?	60%	40%
6. Have CCOs adopted mandatory fee schedules-maxima?	75%	25%
7. Have CCOs adopted ACOEM guidelines?	75%	25%
8. Have providers been trained in ACOEM guidelines?	20%	80%
9. Have CCOs adopted TD, PD and apportionment rules?	35%	65%
10. Have providers been trained in these rules?	10%	90%
11. Have the numbers of bills up for repricing increased?	20%	80%
12. Has the volume of Workers Comp cases per unit payroll declined?	85%	15%
13. Do PPOs/MPNs share savings with payers?	45%	55%
14. Do CCOs (UR, BR) share savings with payers?	70%	30%
15. Is it difficult to meet State MPN regulations?	35%	65%

Source: BRS Telephone Survey of PPO/MPN Experts (BRS PPO/MPN Experts Survey) California, October 2005-January 2006.

- The percentage of bills re-priced in the bill review process has stayed the same or declined a relatively small amount over the past 6 months (about 5 percent). This suggests that implementation of strengthened UR/UM guidelines may be having some impacts. It is also consistent with a possible reduction in the number of workers' compensation cases per thousand dollars of payroll is declining. Several respondents indeed indicated that workers' compensation cases per thousand employees have declined during the past six months by about 5 percent. (In-Depth Interviews; BRS PPO/MPN Experts Survey)
- Most respondents (60 percent) believe that medical control of injured workers, de facto, has fallen or will fall mostly to the UR/UM entities within CCOs, and/or trained MPN providers. Some 40 percent believe that claims adjusters of insurers and/or self-insured employers will retain the upper hand in terms of medical control (BRS PPO/MPN Experts Survey; Exhibit).

- Most respondents (80 percent) maintain that the activities of MPNs and individual providers, by themselves, have, so far, resulted in modest reductions in cost per medical claim, in the neighborhood of the higher end of the 0 percent to 5 percent range. Several respondents (20 percent) held that the impact was about 6 to 10 percent. Cost reductions exclusively due to MPNs are expected to increase in the near future as MPNs become more customized and providers trained. The key factor will probably be increased coordination between network providers and the UR/UM function (BRS PPO/MPN Experts Survey).

Exhibit III.31. Reforms' Impacts on Claims Cost and Premiums, California 2005

Impact Category/Percent Decline	0-5%	5-10%	11-20%	21-30%	31-40%	>40%	Total
PPO/MPN Impact on Medical Claims Cost	80%	20%	0	0	0	0	100%
All Reforms' Impact on Medical Claims Cost	0%	30%	55%	15%	0	0	100%
All Reforms' Impact on Premiums	0%	5%	20%	30%	25%	20%	100%

Source: Ibid.

Chapter III Endnotes

[1] WCIRB Amended 2006 Rate Filing, CDI File #RH-05-046947, September 15, 2005, page A-9
[2] Neuhauser, F., November 2003, http://www.dir.ca.gov/chswc/chswclegaldecaffectmedtreatpractice/ptpfinalrpt.html#3
[3] Neuhauser, F., November 2003, http://www.dir.ca.gov/chswc/chswclegaldecaffectmedtreatpractice/ptpfinalrpt.html#3
[4] Title 8, California Code of Regulations, section 9767.9